

Mill Point Dental Center

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Dr. Marika Stone, D.D.S.

(541) 388-0078 · 775 SW Bonnett Way, Bend, OR 97702, Suite 100

Date: _____

Name: _____ Date of Birth: ____/____/____
First Name Last Name Middle Initial

Social Security # **(Required for insurance)**: _____ - _____ - _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Home/Mailing Address: _____
Street Apt. # City State Zip Code

E-Mail Address: _____ Person Responsible: _____

Occupation: _____ Employer: _____

Spouse Name: _____ Spouse Date of Birth: ____/____/____

Spouse Home Phone: _____ Spouse Cell/Work Phone: _____

Spouse Employer: _____

Appointment Day/Time Preferences: _____

Preferred Pharmacy: _____ Phone: _____

Whom may we thank for referring you? _____

Dental History and Cosmetic Evaluation

What is the reason for this appointment? _____

What concerns do you have? _____

When was your last dental appointment? _____

Who were your previous dental providers? _____

How often do you brush? _____ How often do you floss? _____

What type of toothbrush do you use? _____ What type of toothpaste do you use? _____

Do you have sensitivities to: Heat? Yes___ No___ Cold? Yes___ No___ Air? Yes___ No___

Water? Yes No Biting? Yes No

Are your teeth: Chipped? Yes___ No___ Protruding? Yes___ No___ Crooked? Yes___ No___

Overlapped? Yes___ No___ Discolored? Yes___ No___

Have you had (past or current): Braces? Yes___ No___ Occlusal Guard? Yes___ No___

Retainer? Yes___ No___ Full/Partial Denture? Yes___ No___

Are there spaces between your teeth? Yes___ No___

Do you have periodic exams and cleanings? Yes___ No___

Do you have bleeding gums or gum trouble? Yes___ No___

Have you had a bad dental experience? Yes___ No___

Do you grind or clench your teeth? Yes___ No___

Do you have problems with bad breath? Yes___ No___

Are you pleased with the appearance of your teeth? Yes___ No___

Do you have any habits such as biting pens, thumb sucking, tongue thrusting, etc...? Yes___ No___

Do you have any sugar habits, such as mints, gum, carbonated soda, candy, etc...? Yes___ No___

Do you have old fillings or dental work that makes you less confident of your appearance? Yes___ No___

Mill Point Dental Center: *Health History*

- **Medical allergies?** *(no seasonal or animal allergies)* Yes ___ No ___ *If yes, what?* _____
- **Are you taking any medication or vitamins?** Yes ___ No ___ *If so, please list names, dosages and how often taken:*

- **WOMEN ONLY:** Are you pregnant or trying? Yes ___ No ___ Are you nursing? Yes ___ No ___
 - Are you on any blood thinners (Aspirin, Coumadin, Warfarin, etc...)? _____ Yes ___ No ___
If so, what is your INR/PT? (Check "n/a" box if you have not had) _____ n/a _____
 - Do you take or have you taken Phen-Fen, Redux or Biophosphates? _____ Yes ___ No ___
 - Have you ever been told you need pre-med for dental treatment? *If so, what?* _____ Yes ___ No ___
 - Are you under a physician's care? **Physician Name:** _____ **Phone #:** (____) _____ Yes ___ No ___
 - Are you on a special diet? *If yes, what type of diet?* _____ Yes ___ No ___
 - Have you ever been hospitalized or had a major operation? **Explain:** _____ Yes ___ No ___
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- Have you ever had a serious head/neck injury? **Explain:** _____ Yes ___ No ___
 - Do you use any tobacco products or drugs? *If so, what?* _____ Yes ___ No ___

Please check all that you currently have or have a history of: (Please mark all boxes)

Aids/HIV Positive.....	Yes ___ No ___	Emphysema.....	Yes ___ No ___	Kidney Problems.....	Yes ___ No ___
Alzheimer's.....	Yes ___ No ___	Epilepsy or Seizures.....	Yes ___ No ___	Leukemia.....	Yes ___ No ___
Anaphylaxis.....	Yes ___ No ___	Excessive Bleeding.....	Yes ___ No ___	Liver Disease.....	Yes ___ No ___
Anemia.....	Yes ___ No ___	Excessive Thirst.....	Yes ___ No ___	Osteoporosis.....	Yes ___ No ___
Angina.....	Yes ___ No ___	Fainting Spells/Dizziness	Yes ___ No ___	Osteopenia.....	Yes ___ No ___
Arthritis/Gout.....	Yes ___ No ___	Frequent Cough.....	Yes ___ No ___	Mitral Valve Prolapse....	Yes ___ No ___
Artificial Heart Valve.....	Yes ___ No ___	Frequent Headaches.....	Yes ___ No ___	Pain in Jaw Joints/TMJ...	Yes ___ No ___
Artificial Joint.....	Yes ___ No ___	Glaucoma.....	Yes ___ No ___	Parathyroid Disease.....	Yes ___ No ___
Asthma.....	Yes ___ No ___	GERD.....	Yes ___ No ___	Radiation Treatment.....	Yes ___ No ___
Blood Disease.....	Yes ___ No ___	Hay Fever.....	Yes ___ No ___	Recent Weight Loss.....	Yes ___ No ___
Blood Transfusion.....	Yes ___ No ___	Heart Attack/Failure.....	Yes ___ No ___	Renal Dialysis.....	Yes ___ No ___
Breathing Problems.....	Yes ___ No ___	Heart Murmur.....	Yes ___ No ___	Rheumatic Fever.....	Yes ___ No ___
Bruise Easily.....	Yes ___ No ___	Heart Pace Maker.....	Yes ___ No ___	Shingles.....	Yes ___ No ___
Cancer.....	Yes ___ No ___	Heart Disease.....	Yes ___ No ___	Sinus Trouble.....	Yes ___ No ___
Chemotherapy.....	Yes ___ No ___	Hepatitis A.....	Yes ___ No ___	Stomach Disease.....	Yes ___ No ___
Chest Pain.....	Yes ___ No ___	Hepatitis B.....	Yes ___ No ___	Stroke.....	Yes ___ No ___
Cortisone Medicine.....	Yes ___ No ___	Hepatitis C.....	Yes ___ No ___	Swelling of Limbs.....	Yes ___ No ___
Depression.....	Yes ___ No ___	High Blood Pressure.....	Yes ___ No ___	Thyroid Disease.....	Yes ___ No ___
Diabetes.....	Yes ___ No ___	<i>·If yes, being treated?_</i>	Yes ___ No ___	Tonsillitis.....	Yes ___ No ___
<i>·If yes, taking Insulin?...</i>	Yes ___ No ___	High Cholesterol.....	Yes ___ No ___	Tuberculosis.....	Yes ___ No ___
<i>·Last A1C test score.....</i>	_____	Hives or Rash.....	Yes ___ No ___	Tumors or Growths.....	Yes ___ No ___
Drug Addiction.....	Yes ___ No ___	Intestinal Disease.....	Yes ___ No ___	Ulcers.....	Yes ___ No ___
Easily Winded.....	Yes ___ No ___	Irregular Heartbeat.....	Yes ___ No ___	Yellow Jaundice.....	Yes ___ No ___

- **Do you, or have you had an illness not listed above?** Yes ___ No ___ *If yes, please list/explain:*

Print Name: _____	Signature : _____	Date: _____
Doctor Signature: _____		Date: _____

UPDATES:			
1st: Patient Signature: _____	Dr. Initials: _____	Date: _____	
2nd: Patient Signature: _____	Dr. Initials: _____	Date: _____	

MILL POINT DENTAL CENTER: OFFICE POLICIES

In an effort to maintain a high level of professional care, we have established the following office policies for our patients. Our primary responsibility is to help our patients establish and maintain excellent dental health. Therefore, we would like to explain our guidelines in order to avoid any misunderstanding in the future.

- **We have found that insurances rarely pay 100% of most dental fees; therefore, we ask that all co-payments and estimated patient financial portion be paid for at the time of service**, unless other arrangements have been made prior to appointment (See Financial Options below). **After your insurance has paid, there may be a remaining balance and you will be sent a final statement for that amount.**
- We bill all insurance companies as a courtesy, when you have provided our office with correct, current information. Even though you may have insurance claims pending, you will receive a monthly statement for the outstanding balance of your account. **Though we work very hard in submitting your claims accurately, we cannot accept responsibility for collection on an insurance claim after 60 days or for negotiating a disputed claim.** We do not have control over an insurance companies' interpretation of their responsibility to pay your bill or when our agreement is with you, as your patient. **Be aware, all accounts will be charged a 1.5% interest fee for each month the claim is out, even if it is still out with insurance.** The bill is still ultimately your responsibility to have paid within a 60 day period.
- It is the responsibility of the patient to provide us with a current phone number and address to confirm appointments. **If we are unable to contact you 24 hours prior to your scheduled appointment time, we reserve the right to reschedule your appointment.**
- **Please give a minimum 48 hours notice if you are unable to keep your appointment.** These short cancellations severely limit our ability to provide quality services efficiently because of losses incurred due to last minute cancellations. **If you miss your appointment without adequate notice, a fee of \$50.00 per hour reserved for your appointment time will be charged to your account.**
- **There will be a \$25 fee charged to your account for each returned check.**
- If you are medicated with a drug for a procedure that impairs mental and/or physical abilities, you MUST have a driver bring you to your appointment and be able to take you home. If you are to pay with a check, it must be made out prior to you taking the medication. If a credit card is used, you must pay prior to your appointment date.
- **If your child is under the age of 18, you will be requested to remain on the premises during the appointment.**

FINANCIAL OPTIONS

Dental treatment is an excellent investment in an individual's well being. Financial considerations should not be an obstacle to obtain health. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the following payment options:

- **Cash or Check-** 5% courtesy discount when paid in full at the time of service.
- **Credit Card or Bank Card-** Visa, Master Card, American Express or Discover.
- **CareCredit/Chase Health Advance-** This is a line of credit, subject to credit approval. If application is declined, another form of payment listed above is required. Ask us if you need help getting set up with an account.

I have read the Office Policies, as well as the Financial Options and have provided the correct insurance information, if any. I understand that, regardless of the insurance coverage I may have, I am fully responsible for the payment of my account in a timely fashion.

Print Name: _____ **Date:** _____

Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have been offered/received a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

For office use only: We tried to obtain written acknowledgement of receipt of our Notice to Privacy Practices, but could acknowledgement could not be obtained because:

Individual refused to sign Communication barrier prohibited it An emergency situation prevented it Other

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RECORDS RELEASE

The following patient:

Has requested that their records and films be sent to our office at the address listed above.

This information is strictly confidential and will not be released without the written consent of the patient or guardian, in accordance with HIPAA regulations.

Please release these records at your earliest convenience. The patient will be seen on the following date:

Thank you,

Mill Point Dental Center

Patient or Guardian Signature: _____

Date: ____/____/____