The DENTISTS AT ORENCO FOR KIDS

Welcome to our practice!
We thank you for choosing our team to your family.
The information on this form is important to your health and dental treatment.

PATIENT INFORMATION

TODAY'S DATE:

Patient's Name ❑Mr. ❑Miss_____ Date of Birth _____
Patient's Name ❑Mr. ❑Miss_____ Date of Birth _____
Patient's Name ❑Mr. ❑Miss_____ Date of Birth _____
Patient's Name ❑Mr. ❑Miss_____ Date of Birth _____
Home phone _____ Parent or Guardian Cell Phone_____
Home Address _____ Unit/Apt.____City _____ State _____ Zip _____
Mailing Address _____ Unit/Apt.____ City _____ State _____ Zip _____
Email_____
Parent or Guardian Name: _____ Work Phone_____
Spouse's Name_____Employer _____ Work Phone_____
Whom May We Thank for Inviting You?_____ May we contact them? ❑ Yes ❑ No
How Did You Hear About Us? ❑ Personal Invitation ❑ Professional Referral ❑ Mailer ❑ Yelp!
❑ Web Search ❑ Insurance Company ❑ Facebook ❑ Other - Please Explain_____
Emergency Contact_____Phone_____ Relationship_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____Birthdate_____
Relationship to Patient_____ Social Security #_____ Employer _____
Home phone_____ Cell Phone_____Work Phone_____ Email_____
Home Address _____ Unit/Apt.____City _____ State _____ Zip _____
Mailing Address _____ Unit/Apt.____ City _____ State _____ Zip _____

DENTAL BENEFIT INFORMATION ❑ Not Covered by a Dental Benefit Policy

Primary Dental Benefit Policy
Name of Policy Holder_____ Relationship to Patient_____ Birthdate_____
Social Security Number: _____ Employer_____
Dental Insurance Co._____ Group number_____ Policy ID Number_____
Ins. Co. Address _____City _____State _____ Zip _____
How Much is Your Deductible?_____How Much Have You Used?_____ Max. Annual Benefit_____

Secondary Dental Benefit Policy
Name of Policy Holder_____ Relationship to Patient_____ Birthdate_____
Social Security Number: _____ Employer_____
Dental Insurance Co._____ Group number_____ Policy ID Number_____
Ins. Co. Address _____City _____State _____ Zip _____
How Much is Your Deductible?_____How Much Have You Used?_____ Max. Annual Benefit_____

MEDICAL HEALTH HISTORY

PATIENT'S NAME: _____

Pediatrician _____ Office Phone _____ Date of Last Exam _____

	Y	N
1. Is your child under medical treatment now?_____ If yes, please explain _____	❑	❑
2. Has your child ever been hospitalized for any surgical operation or serious illness within the last 5 years_____ If yes, please explain _____	❑	❑
3. Is your child taking any medication(s) including non-prescription drugs?_____ If yes, what are the medications?_____	❑	❑
4. Does your child have a persistent cough or throat clearing associated with a known illness (lasting more than 3 weeks)?_____	❑	❑

5. Is your child allergic to, or have you reacted adversely to any of the following?

- ❑ Latex rubber
- ❑ Local anesthetics (e.g. Novocain)
- ❑ Penicillin or other antibiotics
- ❑ Metals (e.g. nickel, mercury, etc)
- ❑ Codeine or other narcotics
- ❑ Animals
- ❑ Food
- ❑ Other_____
- ❑ Barbiturates
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Iodine
- ❑ Aspirin
- ❑ Hay fever/seasonal

Does your child have or have ever had any of the following?

	Y	N		Y	N		Y	N
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑			
Hay Fever/Allergies	❑	❑	Fainting/Seizures	❑	❑	Frequently Tired	❑	❑
Tuberculosis	❑	❑	Asthma	❑	❑	Anemia	❑	❑
Radiation Therapy	❑	❑	Low Blood Pressure	❑	❑	Epilepsy/Convulsions	❑	❑
Cancer	❑	❑	Recent Weight Loss	❑	❑	Leukemia	❑	❑
Arthritis	❑	❑	Liver Disease	❑	❑	Diabetes Type I or II	❑	❑
Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑	Kidney Disease	❑	❑
Hepatitis/Jaundice	❑	❑	Respiratory Problems	❑	❑	AIDS or HIV Infection	❑	❑
Mitral Valve Prolapse	❑	❑	Thyroid Problem	❑	❑	Stomach Troubles/Ulcers	❑	❑
Other (Please Explain)	❑	❑	_____ _____					

DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? Y N

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

Reason for Today's Visit _____

	Y	N
Does your child eat between meals?	❑	❑
Were there any teeth (baby or permanent) removed by extraction?	❑	❑
Has your child had any problem with dental treatment in the past?	❑	❑
When does your child brush his/her teeth?_____		
Does your child bite his/her lips or cheeks frequently?	❑	❑
Does your child receive fluoride?	❑	❑
Has your child ever had local anesthetic?	❑	❑
Has your child had a history of cavities?	❑	❑

	Y	N
Has your child ever had occlusal sealants?	❑	❑
Does your child suck his/her thumb?	❑	❑
Has your child had any orthodontic treatment?	❑	❑
Does your child think there is anything wrong with his/her teeth?	❑	❑
Has your child had any of the following injuries to the teeth?		
Falls?	❑	❑
Chips?	❑	❑
Teeth have been knocked out?	❑	❑
Sports Injuries?	❑	❑

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

X _____
Signature of Parent or Guardian

Doctor's Comments _____

_____

_____Signature _____Date_____

BP: _____Pulse:

The DENTISTS
AT ORENCO
FOR KIDS

1322 NE Orenco Station Parkway ● Suite 200 ● Hillsboro, OR 97124

www.DentistsAtOrencoforkids.com

STATEMENT OF FINANCIAL POLICY

Our office is committed to providing your family the highest quality dental care available. In order to achieve this goal we seek your understanding of, and compliance with, our payment policy.

Payment is due at the time services are rendered. We accept American Express, VISA, and MasterCard, Discover credit cards, Care Credit, debit cards, cash and checks.

As a courtesy to our patients who have dental insurance, we will file claims and accept payment directly from your insurance company. Since most procedures are not covered at 100%, we require your payment of the estimated portion not covered by your insurance company at the time of treatment. Please keep in mind the following:

A) Not all services are covered benefits in all contracts. Benefits may vary not only from plan to plan, but from patient to patient. Please familiarize yourself with your insurance coverage. A phone call to the information number on your insurance card to review the benefits applicable to your treatment plan is recommended.

B) Your copayment is due in full at the time of service. We will call your insurance company prior to your initial visit to get an estimate of what your insurance will cover; however, the insurance company will state that **the quote over the phone is not a guarantee of benefit.** The parent/legal guardian is responsible for payment of all patient accounts. We do not get involved in custody and/or financial disputes which may or may not involve court orders.

C) Insurance may pay for all, some, or none of your bill; you are immediately responsible for any portion not paid by your insurance company irrespective of estimates. Please note that your insurance company may base its payment on a fee that they have designated for a procedure, rather than our fee. That fee is typically below our fee, resulting in non-payment of a portion of the claim. If you would like to confirm, prior to commencing treatment, your insurance company's precise participation in any or all of the procedures on your treatment plan, please specify to our front office team members those procedures you would like to have us preauthorize with your insurance company. Preauthorizations can take up to 30 days, and are valid for a limited time period.

D) Accounts that are 60 days old are considered delinquent. A finance charge of $3.00 per month or interest of 1-1/2% per month (whichever is greater) will be added to cover the cost of additional handling. Checks returned for insufficient funds, closed accounts or other problems are subject to a $50.00 service fee. Accounts subject to collection activity will be charged an additional handling fee.

E) Payment for any appointment with treatment costs larger than $750.00 copayment will need to be made at the time of scheduling the appointment. Payment for any sedation appointment will be paid

in full 7 days prior to the confirmed appointment time and day. Failure to make payments will result in a cancelation of the appointment. If for any reason you fail to make your confirmed appointment we reserve the right to keep 10% of the appointment fee.

We must emphasize that as dental care providers, our relationship is with you rather than your insurance company. We are not responsible for constraints, discrepancies, or disputes resulting from the relationship between the patient and his or her insurance provider. Rather, the focus of our relationship with each and every one of our patients is to provide the highest quality dental care available. To that end, we look forward to caring for you!

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Today's Date: _____

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PATIENT APPOINTMENT AGREEMENT

We make every effort to value your time and schedule your appointment time just for you.

We truly appreciate your courtesy of giving us 48 hours' notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

- I acknowledge my appointment is a reservation.
- I acknowledge I am required to provide 48 hours' notice to make any changes to my appointment.
- I acknowledge after my first missed appointment I may be required to leave a $50.00 deposit in order to schedule my next appointment.
- I acknowledge that if I fail to give sufficient notice to change my rescheduled appointment or I fail to show to my appointment, that I may forfeit my deposit of $50.00.
- I acknowledge if for any reason I fail to make my confirmed appointment for either sedation or any treatment over $750.00 that I may forfeit 10% of treatment cost.

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Today's Date: _____

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PARENTAL CONSENT FOR TREATMENT

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

I, _____Parent/legal guardian give the following person(s) permission to accompany my child to dental appointments, allowing them to make financial and treatment decisions on my behalf. I understand that medical history and consent must be updated and signed yearly by a parent or legal guardian. VERBAL CONSENT CANNOT BE ACCEPTED.

Person bringing child must be 18 years or older, must be listed below and will be asked to show a valid ID.

In order to remove someone from this list the parent or legal guardian must come in person with a valid ID and sign a new consent.

Person/Relationship: _____**Phone:**_____

Person/Relationship: _____**Phone:**_____

Person/Relationship: _____**Phone:**_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Today's Date: _____

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HIPAA Privacy Acknowledgement

* You May Refuse to Sign This Acknowledgment *

I have received a copy of this office's Notice of Privacy Practices.

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Today's Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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ELECTRONIC COMMUNICATION AGREEMENT

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: (503) 640-6565

Parent/Guardian Email Address (PLEASE PRINT CLEARLY):

_____

❑ I decline electronic communication.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Today's Date: _____