EMERGENCY TOOTH DOCTOR, PC

PATIENT REGISTRATION FORM

(Please Print)

Today's date:	**Picture ID (agency, state or country where-issued & #):**

PATIENT INFORMATION

Patient's First Name	**Middle Initial:**	**Last:**	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	**Marital status:** ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Preferred Name:	**Birth date:**	**Age:**	**Sex:** ☐ M ☐ F

Street Address:	**Social Security #:**

City:	**State:**	**Zip Code:**	**Email Address:**

Home Phone #:	**Work Phone #:**	**Cell Phone #:**
( )	( )	( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr ______ ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Internet ______ ☐ Other: ______

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the front desk)

Person responsible for bill (if different from patient):	Birth date:	Address (if different):	Home phone #: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer City/State:	Employer phone #: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Primary Insurance:

Subscriber's Name:	Subscriber's Social Security #:	Subscriber Birth Date:	Group #:	Policy #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (please explain): ______

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (please explain): ______

IN CASE OF EMERGENCY

Emergency Contact Name:	Relationship to patient:
Home phone #: ( )	Cell phone #: ( )

EMERGENCY TOOTH DOCTOR, PC

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Your health conditions and medications may have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

If yes, please explain (please use comments section if you need more space):

Question	Answer	If yes, please explain
Are you under a physician's care now?	☐ Yes ☐ No	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	
Do you take or have taken Phen-Fen or Redux?	☐ Yes ☐ No	
Are you on a special diet?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	
Do you use government-controlled or illegal substances?	☐ Yes ☐ No	
Are you taking IV or oral Bisphosphonate (Fosamax, etc.)?	☐ Yes ☐ No	

WOMEN ONLY:

Are you pregnant/trying to get pregnant? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
☐ Other
(*please explain*): ____________________

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes (non-genitals)	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/ Intestinal Disease	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No

Have you ever had any serious illness not listed above? If yes, please explain: ____________________

Comments:

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to have an exam and x-rays

Print Name of Patient: ____________________

Signature of Patient: ____________________ Date ____________

Signature of Parent/Guardian if Patient is a Minor: ____________________ Date ____________

OFFICE POLICY FOR EMERGENCY TOOTH DOCTOR

Hillsboro
405 SE 8th Ave.
Hillsboro, OR 97123
Ph: 503-681-9968
Fax: 503-844-7770

Beaverton
14665 SW Millikan Way
Beaverton, OR 97006
Ph: 503-641-2200
Fax: 503-641-2220

Tigard
14465 SW Pacific Hwy
Tigard, OR 97224
Ph: 971-249-3732
Fax: 971-249-3734

Downtown Portland
1505 SW Broadway
Portland, OR 97201
Ph: 503-222-0090
Fax: 503-222-1033

East Portland
12596 SE Stark St
Plaza 125, Bldg. N
Portland, OR 97233
Ph: 503-252-9657
Fax: 503-256-6909

Vancouver
400 W Fourth Plain Blvd
Vancouver, WA 98660
Ph: 360-975-3198
Fax: 360-718-2594

Camas
217 SE 136th Ave. Ste 102
Vancouver, WA 98684
Ph: 360-896-9595
Fax: 360-896-9703

Thank you for choosing Emergency Tooth Doctor for your dental needs. Before any treatment is performed, we will give you a written estimate of your cost and options called a "treatment plan."

Will you be using Dental Insurance? (Please check one): Yes __ No__

If you marked **YES**, and you are utilizing dental insurance, your treatment plan will include **estimated** insurance payment and **estimated** patient out-of-pocket responsibility. Your insurance provides us with an **estimated** benefit, but they do not guarantee payment. We will submit insurance claims on your behalf for Preferred Provider Plans (PPO), but it is the patient's responsibility to contact their insurance company prior to treatment and understand their benefits. Any remaining balance due after insurance payments received is the patient's responsibility.

_____ (Initial) If we are able to verify your insurance coverage prior to your appointment, we will bill your insurance for the estimated amount covered. Your estimated out-of-pocket cost is due at the time of service.

_____ (Initial) If we are **not** able to verify your insurance prior to your appointment, you are responsible for the full amount for services provided. We will submit a claim to your insurance once we are able to verify your coverage. Once payment is received from insurance, we will reimburse you for the amount.

_____ (Initial) Insurance payment estimates are **ONLY ESTIMATES** based on the information we receive from your insurance company. **Your insurance company does not guarantee payment**. Any remaining balance not covered by your insurance is your responsibility.

Payment Policy for all patients:

We require payment **at the time of service,** and we do not bill patients or accept post-dated checks. If you are not able to provide payment, we may discuss other immediate services or reschedule you on a more financially appropriate date.

We offer a payment plan through a third party company called **Care Credit,** which is subject to approval. You may apply in the office in just minutes, please ask staff for details.

Print Name: ____

Signature: ____**Date:**________________

** I have read and understand the above statements.**

CANCELLATION POLICY FOR EMERGENCY TOOTH DOCTOR

Hillsboro
405 SE 8th Ave.
Hillsboro, OR 97123
Ph: 503-681-9968
Fax: 503-844-7770

Beaverton
14665 SW Millikan Way
Beaverton, OR 97006
Ph: 503-641-2200
Fax: 503-641-2220

Tigard
14465 SW Pacific Hwy
Tigard, OR 97224
Ph: 971-249-3732
Fax: 971-249-3734

Downtown Portland
1505 SW Broadway
Portland, OR 97201
Ph: 503-222-0090
Fax: 503-222-1033

East Portland
12596 SE Stark St
Plaza 125, Bldg. N
Portland, OR 97233
Ph: 503-252-9657
Fax: 503-256-6909

Vancouver
400 W Fourth Plain Blvd
Vancouver, WA 98660
Ph: 360-975-3198
Fax: 360-718-2594

Camas
217 SE 136th Ave. Ste 102
Vancouver, WA 98684
Ph: 360-896-9595
Fax: 360-896-9703

Cancellation Fee:

Emergency Tooth Doctor will call and/or text to confirm your scheduled appointment.

If you cannot make an appointment as scheduled, please notify the office asap. You may call the office directly or text your confirmation to 503-209-9935. Please include your name and which of our locations you are scheduled at.

There will be a **charge of $75.00 if you fail to show for a confirmed appointment** or cancel with less than 4 hours notice for your appointment. For appointments in which we have reserved 2 hours or more time for your treatment, the failure to show charge will be $150.00.

For repeated cancellations, no shows and/or rescheduling it is at our discretion to terminate patient care.

Finance Fee:

We require payment at the time of service, and we do not bill patients or accept post-dated checks. If there is a remaining balance on your account, we will send you a statement via USPS mail.

If you have questions regarding your account balance, please contact us immediately. If we do not receive a response to the statements, there will be a monthly finance charge of 7.5% of the outstanding balance.

Print Name: ______________________________

Signature:______________________________ **Date:**________________

** I have read and understand the above statements **

Emergency Tooth Doctor

HIPAA OMNIBUS RULE STANDARDS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ____________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

***MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

________________________________ ________________________________

Print name of Patient | ***Sign*** for Patient / Guardian of Patient

________________________________ ________________________________

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ____

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☐ First Name Only ☐ Proper Sir Name ☐ Other ____________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

____
Signature of Privacy Officer

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Fax: 360-896-9703

Agreement to Pay for Dental Services

Emergency Tooth Doctor, PC is not contracted with the following commercial insurance companies: Humana, Blue Cross Blue Shield, Regence, Anthem, all HMO/DMO plans. Emergency Tooth Doctor, PC is not contracted to take any state-sponsored or federal-sponsored insurance plans. This includes, but is not limited to:

* Oregon Health Plan (OHP)
* CareOregon
* Health Share of Oregon
* Advantage Dental
* Washington Apple Health
* Molina Health Care
* Medicaid
* Medicare

By signing this agreement, I acknowledge that Emergency Tooth Doctor, PC does not accept my insurance and will not bill my insurance for the services I receive. **I choose to receive treatment with the understanding that I am fully responsible for the full amount due.** I may choose to submit a claim independently to my insurance for reimbursement, but I understand it is my personal responsibility to do so. Emergency Tooth Doctor, PC is not responsible for billing my insurance plan.

If I do not currently have insurance or I am not aware that I have state or federal insurance, I agree to pay for current services rendered even if I become eligible at a future date.

Patient Signature: ______________________________ Date: ____________

Patient Print Name: ______________________________

Witness Signature: ______________________________ Date: ____________

Witness Print Name: ______________________________