dental professionals
Donald W. Ririe, DDS
15495 SW Sequoia Parkway
Portland, OR 97224
(503) 684-8445 • www.SnoozeDentist.com

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name _____ Middle _____ Last Name _____ Preferred Name (if any) _____

Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Best time & number to contact you _____

Contact name & number in case of emergency _____ How did you hear about us? _____

Date of Birth (mm/dd/yyyy) ____ / ____ / ____ Age ____ Social Security # (For Insurance) _____ Driver's License # _____

~ If you make insurance cards available for us to photo copy you do not need to enter your insurance information ~

Employer of Primary Insurance Holder _____ Employer Phone of Primary Insurance Holder _____

Primary Insurance Company _____ Phone _____

Policy # _____ Group # _____

Employer of Secondary Insurance Holder _____ Employer Phone of Secondary Insurance Holder _____

Secondary Insurance Company _____ Phone _____

Policy # _____ Group # _____

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

I, the undersigned hereby authorize the Doctor to take radiographs, study models, photographs, records or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent the Doctor to employ any such assistance as he/she deems appropriate under the law. I further authorize the release of diagnosis, radiographs, patient records, treatments or examinations rendered: to my insurance company, consulting professionals and others I approve.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. Reservations require a great deal of setup and preparation tailored to you and your treatment. Last minute cancellations and missed reservations will be charged $50.00 per half hour scheduled. To avoid this charge, contact our office within 48 hours of your reservation. We do understand, on occasion, last minute things occur. If we both take our commitment to each other seriously, these issues are often avoidable.

I certify that the information given is correct and current. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement. Reservations require payment in full unless approved arrangements have been made. Returned checks will be charged $30. I have also received a copy of the Privacy Policy below on page 2.

Pre-Payment Discount - A discount of 5% is given to Cash or Check, if reservation is paid in full, 14 or more days prior to treatment.

We accept - Visa, Master Card, Discover, and American Express; however no discounts will be given to these forms of payment. Financing is available OAC.

Please sign and date the form when you come into our office

(Patient or Guardian Signature) Print Name Date

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DENTAL HEALTH HISTORY

First Name _____ Last Name _____

Rate your dental health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How do you feel about dental treatment? ☐ Relaxed ☐ A little uneasy ☐ Tense ☐ Anxious ☐ Very Anxious ☐ Major Phobia

Reason for seeking dental care at this time?

Do you have any problems, concerns or pain we need to be aware of?

How often do you brush & floss? Brush Enter Times Per: Enter Floss Enter Times Per: Enter

Date of last dental visit? _____ Date of last dental x-rays? _____ Previous Dentist _____

If you could change your smile, what would you change? _____

Are you interested in seeing yourself with a whiter smile? Yes ☐ No ☐

Please answer Yes or No to the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Hot/Cold sensitive teeth	☐	☐	Grinding/Clinching of teeth	☐	☐	Cold Sores/Oral Lesions
☐	☐	Teeth sensitive to sweets	☐	☐	Face/Mouth pain	☐	☐	Catch food between teeth
☐	☐	Sore/Bleeding gums	☐	☐	Clicking/Popping of jaw	☐	☐	Discolored teeth
☐	☐	Periodontal Disease	☐	☐	Difficulty Opening/Chewing	☐	☐	Loose teeth
☐	☐	Missing teeth	☐	☐	Unsightly Spaced teeth	☐	☐	Chipped or broken teeth
☐	☐	Toothaches	☐	☐	Crooked/Tipped teeth	☐	☐	Gag easily
☐	☐	Offensive/Bad Breath	☐	☐	Growth or lesion in your mouth	☐	☐	Wear dentures or partials
☐	☐	Consume Coffee/Tea	☐	☐	Swollen glands	☐	☐	Is your bite uncomfortable or uneven
☐	☐	Sensitive to metals	☐	☐	Broken filling(s)	☐	☐	Dissatisfied with appearance of your teeth
☐	☐	Unfavorable dental experience	☐	☐	Does jaw pain affect daily routine	☐	☐	Do you prefer to save your teeth

Do you have any disease, condition, or concerns not listed previously that you feel we should know about?

If needed, record or bring to our office a list of additional surgeries, current & recent OTC meds, prescriptions, supplements, and allergies:

Please continue to page 3 - Medical History

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MEDICAL HEALTH HISTORY

First Name _____ Last Name _____ Name of Personal Physician & Office _____ Office Phone _____

Rate your overall health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent Height _____ Weight _____

Select the following drugs you have used at any time:
☐ Fosamax ☐ Aredia ☐ Zometa ☐ Actonel
☐ Didronel ☐ Boniva ☐ Skelid ☐ Bisphosphonate

For Women
☐ Birth Control or Hormones ☐ Possibly Pregnant
☐ Pregnant - Delivery Date: _____ ☐ Nursing

Jaw Discomfort-TMJ
No Yes
☐ ☐

Please answer Yes or No to the following questions:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Problems	☐	☐	Intestinal Problems	☐	☐	Physician required premeds _____
☐	☐	Chest pain	☐	☐	Ulcers	☐	☐	Cancer or Tumor
☐	☐	Shortness of breath	☐	☐	Weight gain or loss	☐	☐	Tuberculosis/Respiratory disease _____
☐	☐	Blood pressure problem	☐	☐	Special diet	☐	☐	Do you drink alcohol?
☐	☐	Heart murmur	☐	☐	Constipation/Diarrhea	☐	☐	Do you smoke?
☐	☐	Heart valve problem	☐	☐	Kidney or bladder problems	☐	☐	Use recreational drugs
☐	☐	Taking heart medication	☐	☐	Bone or Joint Problems	☐	☐	History of alcohol or drug abuse
☐	☐	Rheumatic fever	☐	☐	Arthritis	☐	☐	Jaundice or liver trouble
☐	☐	Pacemaker	☐	☐	Back or neck pain	☐	☐	HIV +/AIDS
☐	☐	Artificial heart valve	☐	☐	Joint replacement	☐	☐	Glaucoma
☐	☐	Blood Problems	☐	☐	Diabetes	☐	☐	Narrow angle glaucoma
☐	☐	Frequent nosebleeds	☐	☐	Dry mouth or constantly thirsty	☐	☐	Slow clotting
☐	☐	Abnormal bleeding	☐	☐	Family history of diabetes	☐	☐	Do you wear contact lenses
☐	☐	Blood disease (anemia)	☐	☐	If you have diabetes, is it controlled	☐	☐	Hempohilia
☐	☐	Ever require a blood transfusion			HA-1C Score _____ Date _____	☐	☐	Hepatitis? Type _____
☐	☐	Allergy Problems	☐	☐	Fainting spells, seizures, epilepsy	☐	☐	Fainting spells
☐	☐	Hay fever	☐	☐	Stroke(s)	☐	☐	Herpes or other STD _____
☐	☐	Sinus problems	☐	☐	Frequent or severe headaches	☐	☐	Emphysema
☐	☐	Asthma	☐	☐	Thyroid problems	☐	☐	Lung disease or COPD

Please answer the following - If none, write none. You may also bring your pre-made list to our office

Have you ever had surgery? Yes ☐ No ☐ If yes, please list _____

List ALL medications you CURRENTLY take (OTC and Prescription)

List ANY medications you've taken in the last year not listed above _____

List ALL allergies (Example: Aspirin, Antibiotics, Latex, Foods) _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Dental Professionals of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Dental Professionals or its employees liable in the event of death or injury.

Please sign and date the form when you come into our office

Print Form

(Patient or Guardian Signature) Print Name Date

Official Use Only

☐ None
☐ IV
☐ D1 + T1
☐ D2 + T1
☐ T1
☐ T2
☐ All In Office

B / P _____ / _____
Pulse: _____
O2: _____

Yes No
☐ ☐ Premed?
☐ ☐ Xerostomia

ASA: I II III

Sedation Medication Interactions:

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April of 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the top of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. A service, copy, and shipping charge may apply to the sending of personal information. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address / phone numbers above

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number (503) 684-8445.