



OAK HILLS DENTISTRY

HIPAA Acknowledgement & Consent

The staff at Oak Hills Dentistry is committed to maintaining the confidentiality of your personal, financial and health information. We are required by applicable federal and state laws to maintain the privacy of your personal health information. We are also required to give you this notice. This notice took effect in April 2003 and will remain in effect until we replace it.

By signing this form, you consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge that you are aware of our needs to share information and received your rights notification explaining in detail our office policy and information sharing policy.

You have the right to revoke this consent at any time by giving us written notification. We will honor the request from the day we received your written notification. Please understand that it will not affect any action taken before we received the revocation, and we may decline to treat you or continue treating you if you revoke this consent.

We reserve the right to change our privacy policies described in our office patient right privacy policy and information practices. If we do change our practices, we will make available a revised patient and information privacy update statement.

We request that you provide notification to us of any changes in your personal information we maintain for you in a timely manner.

You may obtain a copy of Notice of Privacy Practices by contacting us at 503-690-0400 or mailing us your request in writing to: Oak Hills Dentistry Attn: Dr. Bradstreet 14740 NW Cornell Rd Ste 120 Portland, OR 97229

By signing this form, you confirm you have read the above information and have received a copy of this office's Notice of Privacy Practices. Your signature also gives consent to Dr. Tyler Bradstreet, DMD & staff to use and disclose your protected health information to carry out treatment, payment activities and health care operations.

Patient Name (Please Print)

Patient Signature (Parent or Guardian if Patient is a Minor)

Date

For Office Use Only

We attempted to obtain a written acknowledgement of Receipt of Notice of Privacy Policy and Information Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier kept us from obtaining acknowledgement
- An emergency situation kept us from obtaining acknowledgement
- Other _____



OAK HILLS DENTISTRY

Financial Policy

★ **PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED OUT OF POCKET AMOUNT.** ★

If you have dental insurance, we will help prepare & submit your dental insurance claims as a courtesy to you. By signing this form, you acknowledge any estimate given, is an estimate only and you are financially responsible for all charges regardless of your insurance coverage. Your signature on this form authorizes Oak Hills Dentistry to release pertinent information to your insurance company including records of treatment rendered, diagnosis, x-rays, and chart notes and you authorize insurance payments to come directly to Oak Hills Dentistry.

If it becomes necessary to effect collections of any amount owed on your account, you will be responsible for all costs and expenses including rebilling and interest charges, missed appointment fees, all collections costs, and reasonable attorney fees. Any account sent to collections will be assessed an additional \$100.00 processing fee. Your signature on this form acknowledges and agrees to these terms.

Payment plans and special arrangements must be made *prior* to treatment and approved by the office manager.

Returned checks will be charged a flat rate of \$25.00 per check, per incident.

Balances older than 60 days from the date of service, regardless of insurance, may be subject to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a \$5.00 rebilling fee- whichever is greater) and applied monthly to any unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through Care Credit, an outside financing group.

Broken Appointment Policy

When you make an appointment with us, we reserve time exclusively for you because you are important to us. Should you need to make any changes to your scheduled appointment, we kindly ask that you give us 48 business hours' notice. Broken appointments without 48 business hours' notice, may be assessed a fee of \$25.00 per half hour of scheduled time.

If you would like more information or have any questions, please let us know. We are always happy to help!

Patient Name (Please Print)

Patient Signature (Parent or Guardian if Patient is a Minor)

Date

Patient Information

Patient Name: _____
Last Name First Name Middle

Preferred Name: _____ Family Status: Single Married Child Other

Mailing Address: _____
Street Apt/Unit# City State Zip

Patient Birthdate: _____ Social Security # (If patient is over 18yrs old) : _____

Sex: M F Prefer not to answer

Email Address: _____

Primary Phone #: _____ Home Cell Work Secondary Phone #: _____ Home Cell Work

Responsible Party/Guardian Information

*If this information is the same as above you may skip the next 4 lines and continue at the *Employer information section.

Name: _____ Birthdate: _____
Last Name First Name Middle

Social Security #: _____ Relationship to Patient: _____

Mailing Address: _____
Street Apt/Unit# City State Zip

Primary Phone #: _____ Home Cell Work Secondary Phone #: _____ Home Cell Work

*Employer: _____ Occupation: _____ # Years Employed: _____

Spouse Name: _____ Birthdate: _____ SS #: _____
Last First Middle

Spouse Primary Phone #: _____ HM Cell WRK Spouse Secondary Phone #: _____ HM Cell WRK

Spouse Employer: _____ Occupation: _____ # Years Employed: _____

Dental Insurance Information

Subscriber Name: _____ Subscriber ID or SS #: _____

Subscriber DOB: _____ Insur Co. Name: _____ Insur Phone #: _____ Group #: _____

Subscriber Address (if different from patient): _____ Subscriber Employer: _____

Do you have dual coverage? Yes No If yes:

Secondary Subscriber Name: _____ ID or SS #: _____ Subscriber DOB: _____

Subscriber Address (if different from patient): _____ Subscriber Employer: _____

2nd Insurance Co. Name: _____ 2nd Insurance Phone #: _____ Group #: _____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Medical Health

DOB: _____

What would you consider your general health to be? Excellent Good Fair Poor

Primary Care Physician Name: _____ Physician Phone #: _____

Are you taking any medication? Yes No If Yes, Please List Below:

Medication: _____	For what purpose? _____
Medication: _____	For what purpose? _____
Medication: _____	For what purpose? _____
Medication: _____	For what purpose? _____

Do you have OR have you ever had the following medical conditions:

Abnormal Blood Pressure: High/Low	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Abnormal Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>
AFib	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis Type _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Angina (Chest Pain)	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV+/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease/Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Bones/Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lung Disease/COPD	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma/Difficulty Breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental Illness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy or Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Organ Transplant	Yes <input type="checkbox"/> No <input type="checkbox"/>
Colitis/Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Defect	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dementia/Alzheimer's Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever/Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Steroid Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy/Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Frequent/Severe Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Substance Abuse Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hay Fever/Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis (TB)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumors	Yes <input type="checkbox"/> No <input type="checkbox"/>

Are you allergic to: Penicillin: Codeine: Sulfa Drugs: Erythromycin: Dental Anesthetics: Iodine: Metals/Nickel:

Aspirin: Ibuprofen: Latex/Plastics: Barbiturates: Any Other Medications/Materials? _____

Do you take antibiotics prior to dental treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking any blood thinners?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you subject to prolonged bleeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you subject to fainting spells?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have excessive urination and/or thirst?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you use tobacco products?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever had or are you currently getting IV Zoledronic Acid Treatments (such as Zometa or Reclast)?			Yes <input type="checkbox"/> No <input type="checkbox"/>

Please list any Major Surgeries: Year: _____ Type of Surgery: _____ Year: _____ Type of Surgery: _____

If you have any other medical problems not listed please explain: _____

Women: Are you or could you be pregnant? Yes No If yes, expected due date? _____ Are you nursing? Yes No

Dental Health: Previous Dentist's Name _____ Previous Dentist's Phone #: _____

Reason for your visit today: _____ When was your last dental visit? _____

Have you ever experienced problems associated with previous dental treatment? Yes No Explain: _____

Are you experiencing any tooth, mouth, or jaw pain? Yes No Explain: _____

Are your teeth sensitive to hot, cold, or anything else? Yes No Explain: _____

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

Type of bristles on your toothbrush? Soft Medium Hard Do you use an electric toothbrush and/or WaterPik? Yes No

Do your gums bleed when brushing? Yes No Do your gums bleed when flossing? Yes No

Do you use a Night Guard? Yes No Do you use a Sleep Apnea Device or Snore Guard? Yes No

Are you satisfied with the appearance of your teeth? Yes No If no, what would you change? _____

Would you like your teeth to be whiter? Yes No

I affirm that the information I have provided on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the staff of Oak Hills Dentistry to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Name (Please Print) _____

Patient Signature _____

Today's Date _____