Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Do you have or have you had the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

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 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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

Signature _____ Date _____

FINANCIAL POLICY

Dr. Knechtel believes in giving the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment plan as well as our financial policy.

Financial Policy: Payment is expected at the time of service unless prior arrangements have been made. We accept all credit cards and outside financing is available.

Insurance: Your dental insurance is a contract between you and the dental insurance company. Therefore, the patient or guardian is responsible for the bill, regardless of insurance coverage. You are responsible for knowing what your insurance covers. As a courtesy to our patients we will bill your insurance company; however the responsibility for payment will remain with you. In order for us to bill your insurance company we must have all necessary dental insurance information such as; insurance company, employer, group number, and insureds social security number or id number.
Insured dental patients are expected to pay the estimated co payments or non insurance payments and deductibles at the time of service. If your insurance has not paid within 45 days of treatment you will need to pay your account in full.

We do not bill worker's compensation plans.

I authorize the doctor to release any medical or dental information required to process my insurance claims. I further authorize that my insurance benefits be paid directly to the dentist. This office can make no guarantee of the insurance estimate of payment.

Divorced parents: The parent who brings in the child for treatment is the responsible party and the person who needs to take care of the account in full.

Federal Truth In Lending Disclosure: All amounts reflected are due and payable upon receipt. All amounts not received after 60 days of treatment shall accrue a 1.5% finance charge simple interest 18% APR pursuant to ORS 82.010. All accounts are due in full within 60 days.

Returned checks: There will be a 20.00 service charge for any returned checks

Missed Appointment Fee: There will be a $50.00 charge for broken appointments cancelled without 48 hours notice. Exceptions to this rule can be determined only on an individual basis according to circumstances.

Attorney and Collections: If my account is turned over to a collection agency or the hands of an attorney for collection, I will pay the doctor's attorney fees and collection costs. I give my permission to give any information deemed necessary to the collection agency or attorney so they may collect my overdue account.

Our goal is to make your visits as pleasant as possible. If you have any questions regarding your treatment plan or our financial policies, please do not hesitate to ask.

I certify that I have read and fully understand the policies of this office.

_____

Patient Signature Date

Kurt W. Knechtel D.M.D
Cosmetic and Family Dentistry

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 is important to us.
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. This notice takes effect immediately and will remain in effect until we replace it. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

Uses and Disclosures of Health Information

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 Operation: Healthcare operations include quality assesment 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.

To your Family and Friends: 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.

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. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevent to the person's involvement in your healthcare. We will also use our professional judgement for your best interest in allowing a person to pick up dental supplies, x-rays or other similar forms of health care information.

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

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably belive 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.

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
You have the right to look at or get copies of your health information, with limited exception. We may charge you a reasonable cost based fee for expenses such as copies and staff time. You have the right to request that we ammend your health information. We may deny your request under certain circumstances. We support your right to the privacy of your health information. If you are concerned that we may have violatd your privacy rights, please contact our office in writing.

Kurt Knechtel D.M.D.
Cosmetic and Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

(You May Refuse to Sign this Agreement)

I,_____, have read a copy of this office's NOTICE OF PRIVACY PRACTICES and have been offered a written copy.

_____
Print name

_____
Signature

_____
Date

_____
For Office Use Only

We attempted to obtain written acknowledgement of reciept 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)

_____

_____