GREEN TREE DENTAL

1103 3RD ST.
TILLAMOOK, OR 97141
(503) 842-6666

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

CITY ST ZIP CODE

HOME:
CELL:
WORK:

E-Mail:

How did you hear about our office?

EMPLOYMENT INFORMATION

Employer: Occupation:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: Treatment Type:

☐Y☐N Are you currently having dental discomfort? If yes, explain:
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain:
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain:
☐Y☐N Are your teeth sensitive to cold, hot, sweets, or pressure?
☐Y☐N Orthodontic appliances (braces) now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Is your mouth dry?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you have any clicking, popping, or discomfort in the jaw?
☐Y☐N Do you have sores or ulcers in your mouth?

What is the reason for your dental visit today?

Is there anything you would like to change about your smile?

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PRIMARY PHYSICIAN INFORMATION

Physician: ..... Telephone: .....

Clinic/Facility: City/State/Zip:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Do you drink alcoholic beverages?
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint (hip, knee, shoulder)? Date:_____
☐Y☐N Are you taking, or have taken, any diet drugs such as Pondimin, Redux, or fen-phen?

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

- Are you taking or scheduled to begin taking alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease? ☐Y☐N
- Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? ☐Y☐N
  Date Treatment Began: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ABNORMAL BLEEDING
☐ACID REFLUX/HEARTBURN
☐AIDS/HIV
☐ANEMIA
☐ANGINA
☐ANOREXIA/BULIMIA
☐ANXIETY
☐ARTERIOSCLEROSIS
☐ARTIFICIAL HEART VALVE
☐ARTHRITIS
☐ASTHMA
☐AUTOIMMUNE DISEASE
☐BLEEDING DISORDER/HEMOPHILIA
☐BLOOD TRANSFUSION YEAR:
☐BRONCHITIS
☐CANCER/MALIGNANCY
☐CARDIOVASCULAR DISEASE
☐CHEST PAINS
☐CHRONIC PAIN
☐CONGENITAL HEART DEFECTS
☐CONGESTIVE HEART FAILURE
☐DAMAGED HEART VALVES
☐DIABETES TYPE:_____
☐DIZZINESS/FAINTING
☐EMPHYSEMA
☐EPILEPSY/SEIZURES
☐EXCESSIVE URINATION
☐GASTROINTESTINAL DISEASE
☐GLAUCOMA
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐LOW BLOOD PRESSURE
☐MIGRAINES
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐OSTEOPOROSIS
☐PACEMAKER
☐PERSISTENT SWOLLEN GLAND(NECK)
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMOTHERAPY
☐RESPIRATORY DISEASE
☐RHEUMATIC HEAR DISEASE
☐RHEUMATIC FEVER
☐RHEUMATOID ARTHRITIS
☐SINUS PROBLEMS
☐SLEEP DISORDER
☐STROKE
☐SYSTEMIC LUPUS ERYTHEMATOSUS
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐WEIGHT LOSS (RAPID)
☐OTHER – PLEASE LIST: .....

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐OTHER – PLEASE LIST: .....
☐CODEINE
☐DAIRY
☐LATEX
☐FOOD
☐METAL SENSITIVITY
☐IODINE
☐ANIMALS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

Patient's Signature:_____ Date:_____

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Patient name: _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care.
The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and CareCredit. Other financing may be available upon request and approval.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee. ***Initial here*** _____

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask

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Patient Treatment and Financial Policy (cont'd)

that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

· We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Missed Appointment (s) and Cancellations:
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or for rescheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A $40 charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice. ***Initial here*** _____

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient /Parent name printed _____

Patient /Parent signature _____ Date _____

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Preferred Contact Methods

Please check appropriate boxes:

Appointment Confirmation	☐ Text	☐ Email	☐ Home Phone	☐ Work Phone	☐ Cell Phone
Appointment Reminder	☐ Text	☐ Email	☐ Home Phone	☐ Work Phone	☐ Cell Phone
All other communications	☐ Text	☐ Email	☐ Home Phone	☐ Work Phone	☐ Cell Phone

Update your contact information:
(Please print clearly)

Home Phone:	
Work Phone:	
Cell Phone:	
Email:	

If multiple patients (children, spouse, etc.) use these same contact methods, please list them all below.

_____

_____

_____

_____

_____

_____

_____