



The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The more you communicate to us, enables us to better care for you.

Today's Date: _____ E-mail Address: _____

Name:

Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo # _____

City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: (____) _____ Cell: (____) _____

Work Phone: (____) _____ Ext: _____ Other #: _____

Employer: _____

Employer's Address: _____

City State Zip

Length of employment: _____ Occupation: _____

When are the best times to reach you? _____ am _____ pm

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle) Last Visit Date: _____

Spouse Information:

His / Her Name: _____

Employer: _____

Position: _____ Social Security #: _____

Work Phone: (____) _____ Birthdate: ____/____/____

Person Responsible for Account:

Name: _____

Employer: _____ Driver's License #: _____

Work Phone: (____) _____ Home Phone: (____) _____

Relationship: _____ Social Security #: _____

Billing Address: _____

In the event of an emergency, whom should we contact?

His / Her Name: _____ Relation: _____

Work Phone: (____) _____ Home Phone: (____) _____

PRIMARY INSURANCE

Dental Insurance?

☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

SECONDARY INSURANCE

Dental Insurance?

☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

I affirm that the information I have given today 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.

Signature

Date

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

My method of payment will be _____

Signature

Date

Thank you for filling out this form completely.
If you have any questions at any time, please ask us. Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

A NOTICE TO OUR PATIENTS
ABOUT OUR PRIVACY POLICY and INFORMATION PRACTICES

Richard Whipple, D.D.S. and staff are committed to maintaining the confidentiality of your personal, financial, and health information. State and Federal law requires us to inform you of our policy and practices as long as we provide you services.

How we protect your Personal Information:

We authorize individuals to access your personal information only to the extent necessary to conduct our business of serving you, such as making and confirming dental appointments, submitting insurance claims, securing insurance benefit information, and submitting applications for third party payment arrangements per your request. We take steps to secure our building, patient files, and electronic systems from unauthorized access. Our employees are trained regarding confidentiality and are held to strict Office Policy and Procedures regarding your personal and health information, both written and verbal. All employees are subject to discipline if they violate these procedures.

Information we collect:

Examples of your personal information include: your name, Social Security Number, address, telephone number, employment, medical history, health records, claims information, and drivers license number.

Information we share:

We may share your personal or health information with other third parties with or without prior authorization only **for our normal business functions**. Examples of our normal business functions include:

- Submission of Dental Claims
- Referrals to Specialists
- Request from other healthcare providers
- Request to or from your selected pharmacy
- Processing transactions that you request
- Appointment notification via postcards, voice messages, or other written or verbal means

Patient Rights:

We honor your right to request access to your personal information. To do so, you must submit a written request describing the information you are requesting. There will be a .10 per page or \$25.00 per hour charge for staff time to retrieve and copy the requested information plus postage. If we are able to locate and retrieve the information within 30 days from your request we will:

- Inform you of the nature and substance of the personal information either in writing or by telephone.
- Permit you to see a copy, in person, the requested information or to obtain a copy by mail, whichever you prefer.
- Disclose the persons to whom we've shared your personal information within the last six years, from April 14, 2003 or if not available, the names of the organizations or persons to whom the information is normally disclosed.
- Provide a summary of the procedures by which you may request correction, amendment, or deletion of personal information.

If you request a correction, amendment, or deletion of personal information we will correct, amend, or delete your personal information or we will notify you of our refusal. You may submit a statement telling us what you believe to be relevant or fair information and the reasons that you disagree with our decision. Your statements will be filed with your personal information.

Richard Whipple, D.D.S.

Use and Disclosure of Health Information Consent Form

Consent: By signing this form, you do consent to our use and disclosure of your personal health information to carry our treatment, payment activities and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office Privacy Policy and Information Sharing Policy.

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this Consent.

Changes to Privacy Practice: We reserve the right to change our privacy practices described in our Patient Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patient Rights Privacy Policy and Information Practice statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to, health history information, address, telephone number, active insurance policy, and change in employer.

I, _____, have read and understand the above information.
I understand that by signing this form I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

Consenting Patient Information:

Name: _____ Date of Birth: _____

Address: _____

Telephone: () _____ () _____ () _____
Home Work Cell

Minor Children also covered by this consent

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Richard Whipple, D.D.S.

Privacy Policy and Information Practices Patient Rights Statement
Patient Acknowledgement of Receipt

I, _____, have received a copy of the above
Please Print Name
named office's Privacy Policy and Information Practices.

Signature: _____

Date: _____

Witnessed

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Patient Rights Notice regarding our Office Privacy Policy and Information Practices.

Acknowledgement was not obtained because:

____ Individual refused to sign

____ Communication barriers prohibited us to obtain a signature

____ There was an emergent situation that prevented us from obtaining a signature

____ Minor Patient was not accompanied by an adult to this appointment

Steps taken to deliver our written Patient Rights Notice:

Staff Initials / date

Practice Support Group, Inc.

RICHARD A. WHIPPLE, D.D.S.
11525 SW Durham Rd. D-1
Tigard, Oregon 97224
503-620-6133

OFFICE FINANCIAL POLICY

1- Payment is required at the time services are rendered. We accept cash, check or credit card. (VISA, MASTER CARD OR DEBIT CARD)

2- 10% SENIOR COURTESY: For payment at the time of services 62 years or older. 5% if VISA, MASTER CARD or DEBIT CARD.

3- DENTAL INSURANCE: If you are covered by an insurance policy, your patient estimated portion is required at time services are rendered.

4- Any account carried over 90 days will have a 1.5% per month finance charge.

5- As a courtesy, this office will be happy to bill your insurance company, however the charges incurred and benefits used are the sole responsibility of the patient.

6- Patient estimated portion after insurance is due on first treatment appointment for (crowns, bridges, dentures, implants and root canals). For special circumstances, arrangements must be made with financial coordinator.

7- If your account is turned over for COLLECTION there will be a filling fee of \$100 debited to your account.

Should it be necessary for you to change your appointment time, a minimum of 24-hour notice is required. Without 24 hour notice there will be a minimum fee charged of \$50. No fee is charged for broken appointments with advance notice.

Your signature indicates your understanding and acceptance of the financial arrangement as stated above.

Signed _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			32. neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. STI / STD _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / street drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>			
13. emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>			
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>			
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>			
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>			
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>			
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>			
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>			
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

ARE YOU:

	YES	NO
46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
47. aware of a change in your health (i.e. fever, new cough) _____	<input type="checkbox"/>	<input type="checkbox"/>
48. taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
51. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
52. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS



7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT



11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE



21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you frequently get food caught between any teeth? _____ ☐ ☐

GUM AND BONE



28. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____