



Welcome! Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

### PATIENT INFORMATION (Confidential)

Name: \_\_\_\_\_ Social Security: \_\_\_\_\_ Date: \_\_\_\_\_ Birthday \_\_\_\_\_ Gender: (M/F)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
Number of Children in Household (per age group): \_\_\_\_\_ 0–23 mos. \_\_\_\_\_ 24 mos.–5 yrs. \_\_\_\_\_ 6–15 yrs. \_\_\_\_\_ 16 yrs. & older  
Patient's or Parent's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Spouse or Parent'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: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ Birthday: \_\_\_\_\_ Social Security: \_\_\_\_\_

### INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Date Employed: \_\_\_\_\_ Birthday: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Union/Local #: \_\_\_\_\_ Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insurance Company Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

Do you have additional insurance? If yes, please complete the section below.

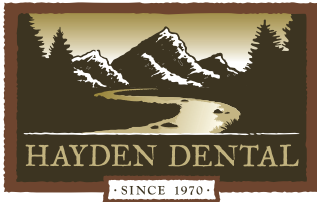
Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Social Security: \_\_\_\_\_ Date Employed: \_\_\_\_\_  
Birthday: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Union/Local #: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

### I have received a copy of this office's NOTICE OF PRIVACY PRACTICE

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

#### FOR OFFICE USE ONLY:

- We attempted written acknowledgement of receipt 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)



## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and results of any treatment or examination rendered to me or my child during the period of such dental care to third party payers 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 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.

Signature of Patient (or Parent if Minor): \_\_\_\_\_ Date: \_\_\_\_\_

### PATIENT MEDICAL HISTORY

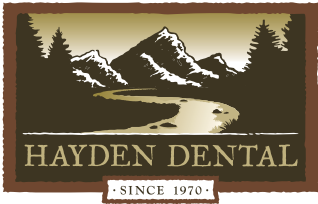
	Yes	No		Yes	No
1. Are you under medical treatment now? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	7. Please complete the following:		
2. Have you been hospitalized for any surgical operation or serious illness within the last year? If yes, please explain: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you allergic to or have you had any reactions to the following medications?			Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Anti-inflammatories.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen.....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list) _____			Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Women Only:			Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
a) Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you taking any medication(s) or drugs? If yes, list medication, condition it treats, and how often it is taken:			Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
<i>Medication</i>	<i>Condition</i>	<i>How Often</i>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>
			Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis – please circle: A B C.....	<input type="checkbox"/>	<input type="checkbox"/>
			Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
			AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>
			Psychiatric Condition.....	<input type="checkbox"/>	<input type="checkbox"/>
			Hemophilia/Bleeding Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____		
6. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<div style="display: flex; justify-content: space-between;"> <div> <p>For office use only (question 6):</p> <p>a) Patient advised to quit? <input type="checkbox"/></p> <p>b) Patient is interesting in quitting? <input type="checkbox"/></p> <p>c) Discussed quit materials/quit-line? <input type="checkbox"/></p> </div> <div> <p>Dr. Initial: _____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> </div> </div>		
If yes, type of tobacco user:					
How frequently:					

### PATIENT DENTAL HISTORY

1. Please list reason for visit today: _____	3. Name of previous Dentist and Location: _____	
2. State long term dental goals: _____		
1. Do your gums bleed while brushing or flossing? <input type="checkbox"/>	5. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/>	
2. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/>	6. Have you had any orthodontic treatment? <input type="checkbox"/>	
3. Have you had any head, neck or jaw injuries? <input type="checkbox"/>	If yes, date of placement: _____	
4. Do you clench or grind your teeth? <input type="checkbox"/>	7. Are you interested in improving your smile (whiter teeth)? <input type="checkbox"/>	

Reviewed by: _____	Update: _____	Update: _____	Update: _____
Update: _____	Update: _____	Update: _____	Update: _____

PHYSICIAN: \_\_\_\_\_ OFFICE PHONE: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_



**CONSENT TO DENTAL PROCEDURES, ADMINISTRATION OF ANESTHETICS, SEDATIVES AND THE RENDERING OF OTHER SERVICES.**

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

1. I hereby authorize Dr. Hayden or Associate Dentist and/or such assistants as may be selected, to perform Routine Dental Care upon the above named and/or any other therapeutic procedure that his/her/their judgement may dictate to be advisable for the patient's well-being.
2. The nature and purpose of the procedure and anesthetic, the risks involved, and the possibility of complications has been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The advantages and inherent risks of anesthesia and sedation have been explained to me and I authorize the administration of such anesthesia and sedation as may be considered necessary or desirable.
3. I authorize that any specimens, tissue or parts removed from the patient may be disposed of in accordance with established practice.
4. I further authorize the performance by any qualified person of any other services which are deemed to be necessary or advisable.
5. If in Dr. Hayden/Associate Dentist's opinion, further observation of the above named is indicated after an anesthetic or procedure, the above named agrees to be transported by ambulance at his/her personal expense to a mutually satisfactory hospital in the local area, and to be admitted for observation and any necessary treatment.
6. If in Dr. Hayden/Associate Dentist's opinion, the above named requires the services of a specialist, he/she agrees to accept the referral and will be responsible for any expense that may be incurred.
7. I certify that I have read this Consent, or that it has been read to me, and that I understand the above. The nature and purpose of such operation(s), procedure(s), treatment(s), and/or services and the reasons why the same is (are) considered necessary or advisable has been explained to me.

Signature of Patient: \_\_\_\_\_

(or Person Authorized to Sign for Patient): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**CONTINUING CONSENT**

Procedure

Initials

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

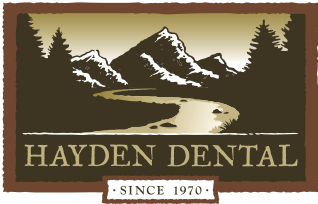
\_\_\_\_\_

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\_\_\_\_\_



## HAYDEN FAMILY DENTISTRY GROUP, P.C. PAYMENT POLICY

Cash / Check / Visa / Mastercard / Discover / AmEx  
Payment is due at time of treatment.

### DENTAL INSURANCE

Payment of your percentage of insurance coverage is due at the time of treatment. As a courtesy to our patients, we will bill your insurance. However, if there is no payment from your Insurance Company to our office within 60 days, or payment is lower than the total bill, you will be responsible for the balance in full at that time. We are not able to negotiate with your Insurance Company on your behalf.

### OREGON HEALTH PLAN

OHP will be billed for covered services. Any co-pays will be billed directly to you from the Division of Medical Assistance Programs (DMAP). In the event a service is not covered by OHP, you will be informed prior to the treatment of the service.

### PAYMENT PLANS

Hayden Family Dentistry Group offers affordable payment plans through an outside lending agency. Applications are available at the front desk and status of approval can be obtained within fifteen minutes.

*As a patient, or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office, as stated above. There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to Finance Charges of 1.5% of the unpaid balance which is an Annual Percentage Rate (APR) of 18%.*

*I (we) hereby authorize Hayden Family Dentistry Group, P.C. (HFDG) to furnish my (our) Insurance Company (Companies) all information required concerning my (our) dental care. I hereby assign to Hayden Family Dentistry Group, P.C. all payments to which I may be entitled for dental expenses, and do hereby direct that payment for such expenses be paid directly to Hayden Family Dentistry Group, P.C.*

Signature of Patient or Legal Guardian:

Date:

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Please indicate how you wish to pay for your dental treatment:

Cash: \_\_\_\_\_

Check: \_\_\_\_\_

Credit Card: \_\_\_\_\_

OHP: \_\_\_\_\_

Other: \_\_\_\_\_