Welcome to Healthy Smiles!

We are so pleased to have you in our practice.

We have sent you your new patient forms to fill out before your visit. The first page needs to be filled out completely and signed. Your medical history is very important, so please review it carefully and fill it out as accurately as possible. The last page reviews our office policies and should be signed at the bottom.

Your first visit is an opportunity for us to get to know each other and to identify any of your dental needs. Please arrive fifteen minutes before your appointment, so we can seat you promptly. We have street parking on Fremont and on 73rd Avenue. If you have any trouble finding our office please call our office for assistance, or log onto our website at

www.healthysmilesdentalgroup.com to get directions from Google Maps.

Some tips for you:

- If you use an inhaler, please bring it with you.
- If you take nitroglycerine tablets, please bring them with you.
- If you require dental pre-medication, make sure to take your antibiotic one hour before your scheduled appointment. Patients who require premedication are those with any total joint replacement, and those with valve replacement, or certain heart defects. If you are unsure if you require premedication, please contact our office and ask to speak with Dr. DeMasi or Dr. Saber so they can advise you.
- If you are a diabetic, please make sure to eat regularly and to take your medications as directed. Morning dental appointments are better times for you to receive treatment.
- Unless otherwise instructed, please eat before your visit.

Our office has a twenty-four hour answering service, so if you need to contact us after office hours, you can still call 503-281-6616. If you are unable to keep your reserved time please let us know as soon as possible so we can find a time that better suits you.

We look forward to meeting you!

PATIENT INFORMATION – CONFIDENTIAL

Name: FIRST MI LAST Birth Date: _____ Social Security # _____

Circle your current marital status: Single Married Domestic Partner

Address: STREET CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____ EXT.: _____

Person to Contact in Case of Emergency: _____ Phone: _____

Email: _____ **Reminder Preference: TEXT / EMAIL / PHONE** (please circle)

Are you Solely Responsible for this account? YES NO

If NO list Responsible Party: _____ Phone: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to You: _____

Insured Parties ID # or Social Security #: _____ Birth Date: _____

Insurance Company: _____ Group #: _____

Insurance Co. Phone Number #: _____

DENTAL HISTORY

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to Hot or Cold liquids/foods?	Yes	No
Are your teeth sensitive to Sweet or Sour liquids/foods?	Yes	No
Do you feel pain in any of your teeth?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Have you had any head, neck or jaw injuries?	Yes	No
Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Have you had difficulty with previous extractions?	Yes	No
Have you had prolonged bleeding after an extraction?	Yes	No
Have you had orthodontic (braces) work done?	Yes	No
Have you been instructed in the correct brushing techniques?	Yes	No

Circle any that you have experienced: Clicking Pain Difficulty opening or closing Difficulty chewing

I have read and answered the above questions to the best of my knowledge. I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

SIGNATURE of PATIENT or parent if a minor DATE

Healthy Smiles Dental Group 7306 NE Fremont, Portland, OR 97213
503-281-6616 * http://www.healthysmilesdentalgroup.com

MEDICAL HISTORY - *Please read carefully and be thorough, Thank You.*

Please check all that apply, circle where appropriate and write in the type

- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial valve / stent
- ☐ Congenital Heart Lesion
- ☐ Anemia – Type:
- ☐ Blood Disease - Type:
- ☐ Circulatory Problems
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Tuberculosis / Positive PPD test
- ☐ Asthma
- ☐ Hay Fever
- ☐ Hives
- ☐ Respiratory Disease - Type:
- ☐ Diabetes Type I Type II
- ☐ Thyroid Disease Hyper Hypo
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Hepatitis A B C
- ☐ Liver / Kidney / Heart Transplant
- ☐ Venereal Disease - Type:
- ☐ Cold Sores
- ☐ Positive Test for HIV
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Cancer – Type:
- ☐ Unexplained Weight Loss
- ☐ Tumor – Type:
- ☐ Special Diet
- ☐ Stroke / TIA
- ☐ Epilepsy
- ☐ Seizures
- ☐ Headaches
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Fainting / Dizzy Spells
- ☐ Ulcers
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Rheumatism
- ☐ Blood Transfusion / Dialysis
- ☐ Blood/Thinners (Coumadin)
- ☐ Aspirin taken daily
- ☐ Other – Please Explain: _____

_____

Please list any diseases, conditions or surgeries you have or had that are not listed above.

_____

ALLERGIES - *Check all that apply – Thank You!*

Please check all that apply, circle where appropriate and write in the type

- ☐ Local Anesthetics
- ☐ Penicillin / Antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates
- ☐ Latex
- ☐ No allergies
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Chocolate
- ☐ Other - _____

You made it to the bottom of the form...You're almost done! Please flip this page over... Thanks!

Healthy Smiles Dental Group
7306 NE FREMONT, PORTLAND OR 97213
TEL 503.281.6616 FAX 503.281.6333

Please check all that apply, circle where appropriate and write in the type			
When you walk upstairs / take a walk do you have to stop due to pain in your chest, shortness of breath or fatigue? Yes No			
Do you bruise easily? Yes No			
Have you ever had excessive bleeding requiring special treatments? Yes No			
Do you use tobacco products? Yes No			
Are you currently under a drug contract? Yes No			
Do you use recreational drugs? Yes No			
Are you pregnant? Yes No			
Are you nursing? Yes No			
Are you taking Birth Control Pills? Yes No			
Do you have osteoporosis *or* have you ever taken the following: *(please circle all that apply)*			
Fosamax | Didronel | Boniva | Actonel | Skelid | Zometa | Aredia			
Medical Doctors Name:		**Phone #:**	
CURRENT MEDICATIONS *Please include all prescribed, over the counter, herbal supplements and vitamins*			
1	6	11	16
2	7	12	17
3	8	13	18
4	9	14	19
5	10	15	20

Patient or Guardian Signature **Date**

For Office Use Only: BP ASA Class I II III IV Doctor Signature:

Healthy Smiles Dental Group
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TEL 503.281.6616 FAX 503.281.6333

Healthy Smiles Dental Group

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to ask

Appointments: ***We request 24-hour notice when changing appointments.*** If not notified 24-hours ahead of your appointment a fee **of $50.00** will be charged to your account. We reserve the right to reschedule your appointment if you are late for the appointment scheduled time exclusively for you.
X_____

Fees & payments: ***Payment is expected at the time services are rendered.*** Our fees are determined by what we feel is necessary to provide you with the highest quality of care. If treatment will require multiple visits, you will be given an estimate and asked to make definite financial arrangements.
X_____

Insurance: ***PLEASE REMEMBER THAT NO INSURANCE COMPANY COVERS ALL*** **DENTAL COSTS.**
Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover**. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy.**
The amount your plan pays is determined by the agreement negotiated by your employer with the insurer. Your dental coverage is determined not by your dental needs – but by how much your employer contributes to your plan. Coverage issues can only be addressed by your employer or group plan administrator. *We cannot act as a mediator with the carrier or your employer.* **X**_____

After Hours Emergency Care: We offer a 24 hour answering service to answer your emergency calls. If you need to speak to a doctor, our service will contact us, and we will call you back as soon as possible. Most emergencies can be handled over the phone. If necessary our doctors will see you after hours. If our doctors are out of town a trusted colleague will be available.

I understand and accept the financial policies listed above and have had any or all my questions answered to my satisfaction. **I understand** that I am fully financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid said insurance.

Signature:_____

You can contact us at 503-281-6616 with your emergency needs.
If you feel you require immediate attention, please refer to your nearest emergency care facility.

Healthy Smiles Dental Group * 7306 NE Fremont St * Portland, OR 97213 * 503-281-6616
Business Hours: Monday 8-5, Tuesday 10-7, Thursday 8-5, Friday 8-1

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Healthy Smiles Dental Group. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Healthy Smiles Dental Group reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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