EST. 2000

WAGNER DENTAL CARE

PORTLAND, OREGON

Patient Information:

Last Name:	**First Name:**		**MI:**
Name you Prefer:	**Date of Birth:**		**Social Security #:**
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Mobile Phone:**	**Work Phone:**	**Ext:**
Email:			
Gender: M:[ ] F:[ ] O: [ ]	**Married/Domestic Partner: Y:[ ] N:[ ]**		
How did you hear about us? Drive by:[ ] Social Media/Website:[ ] Insurance:[ ] Family/Friend:[ ]			
Are any other members of your household a patient with us? Y:[ ] N:[ ] Name:			

*Primary Insurance:

Insurance Company Name:		
Primary Subscribers Name(If different from the patient):		**Date of Birth:**
Relationship to Subscriber: Spouse:[ ] Parent:[ ] Other:[ ]		**Subscribers Social Security:**
ID Number:	**Group Number:**	**Effective Date:**
Claims Address:		
Claims Phone Number:		

*Secondary Insurance:

Insurance Company Name:		
Primary Subscribers Name(If different from the patient):		**Date of Birth:**
Relationship to Subscriber: Spouse:[ ] Parent:[ ] Other:[ ]		**Subscribers Social Security:**
ID Number:	**Group Number:**	**Effective Date:**
Claims Address:		
Claims Phone Number:		

***Payment is due at time of service. If patient is covered by insurance, the insurance company will be billed. It is your responsibility, however, to pay your portion at time of service. If the necessary, please discuss other financial arrangements with our billing office.**

Emergency Contact:

Last Name:	**First Name:**	**Spouse/Partner: Y:[ ] N:[ ]**
Primary Phone:	**Secondary Phone:**	**Patient Here: Y:[ ] N:[ ]**

I acknowledged that I am financially responsible for all charges whether or not paid by insurance. The undersigned agrees to pay for all cost and expenses. I hereby authorize the office to release information necessary to secure the payment of benefits.

Signature:

Patient Signature (or Guardian):	**Date:**

Name _____ **DOB** _____

PRIMARY PHYSICIAN INFORMATION

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

Clinic/Facility:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

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

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

.....

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

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

☐ACID REFLUX	☐BULIMIA	☐HEAD INJURIES	☐PREGNANCY
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐PSYCHIATRIC TREATMENT
☐AIDS/HIV	☐CHEMOTHERAPY	☐HEART DISEASE	☐RADIATION
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RESPIRATORY DISEASE
☐ANOREXIA	☐COUGH, PERSISTENT	☐HEPATITIS	☐RHEUMATIC FEVER
☐ANXIETY	☐DEPRESSION	☐HIGH BLOOD PRESSURE	☐SINUS PROBLEMS
☐ARTIFICIAL HEART VALVE	☐DIABETES	☐KIDNEY DISEASE	☐STROKE
☐ARTIFICIAL JOINTS	☐DIZZINESS/FAINTING	☐JAW PAIN	☐THYROID CONDITION
☐ARTHRITIS	☐EPILEPSY/SEIZURES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ASTHMA	☐EXCESSIVE BLEEDING	☐MENTAL DISORDER	☐ULCERS
☐AUTISM/ASPERGER'S	☐FREQUENT HEADACHES	☐PACEMAKER	☐VENEREAL DISEASE
☐BLOOD DISEASE	☐HEARING PROBLEMS	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS	

☐OTHER – PLEASE LIST: .....

MEDICATION INFORMATION

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

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

☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____

CITY ST ZIP CODE

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 Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced?

☐Y☐N Orthodontic appliances 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 Does it hurt to bite or chew?

☐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 want to become a regular continuing care patient in our practice?

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

Patient name: _____

Signature: _____

Date: _____

Wagner Dental Care Financial Agreement

We are committed to providing you with the highest quality dental care and up-to-date information so that you may fully participate in maintaining the best possible oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

- We require payment in full at time of service
- For patients who have insurance, the entire estimated co-pay is due at the time of service.
- With the information your insurance company provides us, we will do our best to provide you an estimate of your co-pay prior to your appointment. Please read your insurance benefit booklet and understand all waiting periods, frequency limitations, age limits any exceptions, and exclusions. If you are "double covered" with 2 insurance companies, be aware of a "duplication clause" and verify whether or not your secondary insurance has standard coordination of benefits or not.
- As a courtesy, we gladly process your insurance claims and estimate the amount not covered by your insurance. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage.
- Returned checks for insufficient funds or closed accounts are subject to a $25.00 fee. If a check is returned, cash, Visa, MasterCard or CareCredit will be the only accepted form of payment.
- We make every effort to honor all time commitments and request that you extend the same courtesy to us. We know that on occasion, circumstances arise that cause a delay in your schedule. If scheduled appointments cannot be kept, please notify our office at least 24 hours in advance. A $50.00 fee will be charged for a cancellation without proper notification

Although we are unable to arrange payment plans through our office, Dr. Wagner offers a credit program through a third party agency, CareCredit. CareCredit is a low, and in some cases, zero-interest credit card, which provides a flexible payment plan and can also be used for a variety of other health care services. More information is available at www.carecredit.com or by stopping by our office to pick up a brochure.

Payment options:

- Cash
- Visa/MasterCard
- CareCredit

I have read and understand the above financial policy of Wagner Dental Care

Signature: _____ Date: _____

Printed Name: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment here at Wagner Family Dental PC is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire lab analysis
- For payment purposes, we may use the services of a billing service
- During dental care operations, we may need a second opinion
- Referral to specialist may require a sharing of information

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding you Protected Health Information, please contact our office at (503) 239-5115.

I have read and understand the above Notice of Privacy Practices.

Signature: _____ Date: _____
(Patient or Legal Guardian)

Printed Name: _____

Request of Records: By signing below, I authorize Wagner Dental Care to share my dental records (via mail, email, hard copy) with me personally or with any future dental providers at my request or the request of the treating provider.

Signature: _____ Date: _____
(Patient or Legal Guardian)

Printed Name: _____