NEW PATIENT REGISTRATION

Welcome!

Thank you for choosing Fountain Valley Dental!

We are committed to providing every adult and child with the highest quality oral healthcare in the most gentle, efficient manner possible. Remember, the more we know about you, the better we can help you reach and maintain your goals. Instructions: Please complete these Registration forms to the best of your knowledge. Then bring the completed and signed forms with you on your next appointment. Thank you!

YOU MAY WANT TO MAKE COPIES OF THESE FORMS FOR YOUR FILES

PATIENT INFORMATION

Patient's Name_____
Last First Initial

Preferred Name_____

Date of Birth_____

Parent's/Guardian's Name (if child under age 18)

_____
Last First Initial

Which of the following describe(s) you current status?

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Minor

Home Address/PO Box_____

City_____State_____Zip_____

Phone#1: ( )_____

Phone#2: ( )_____

Email Address_____

Work Address/PO Box_____

City_____State_____Zip_____

Phone: ( ) Ext#

Patient/Parent Employed by_____

Present Position_____How Long Held____

Spouse/Parent Name_____

Spouse Employed by_____

Present Position_____How Long Held____

Responsible Party for this account_____

Responsible Party Social Security#_____

Method of Payment:

☐ Ins. Co-payment ☐ Credit Card ☐ Cash

Purpose of this visit_____

Other family members who are patients here:_____

_____

DENTAL INSURANCE 1st COVERAGE

Employee Name_____

Date of Birth_____Social Security#_____

Employer_____

Insurance Company Name_____

Address_____

_____

_____

Telephone ( )_____

Group#_____

DENTAL INSURANCE 2nd COVERAGE

Employee Name_____

Date of Birth_____Social Security#_____

Employer_____

Insurance Company Name_____

Address_____

_____

_____

Telephone ( )_____

Group#_____

Whom may we thank for this referral?_____

In case of emergency, please notify:

Closest family member (Name/Phone):_____

_____

_____

Family of friend not living in same house (Name/Phone)_____

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

_____

Patient's Signature (or Responsible Person, if patient is a minor)

Fountain Valley Dental 1400 Fountain Way, Molalla, OR 97038

503-759-3333 • Fax: 503-759-3291 • scheduling@fountainvalleydental.com

FOUNTAIN VALLEY DENTAL

Medical Health History

PATIENT NAME:_____ **DATE:**_____

Name of Medical Doctor: _____Date of Last Visit: _____

Please check Yes or No for those that apply to you.

YES NO
- ☐ ☐ Anemia
- ☐ ☐ Arthritis
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Artificial Joints
- ☐ ☐ Asthma
- ☐ ☐ Blood Disease
- ☐ ☐ Bruise Easily
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Diabetes
- ☐ ☐ Dizziness
- ☐ ☐ Drug Addiction

YES NO
- ☐ ☐ Emphysema
- ☐ ☐ Excessive Bleeding
- ☐ ☐ Fainting
- ☐ ☐ Glaucoma
- ☐ ☐ Heart Conditions
- ☐ ☐ Heart Lesions
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Surgery
- ☐ ☐ Hepatitis: A B C
- ☐ ☐ High Blood Pressure
- ☐ ☐ HIV Positive
- ☐ ☐ Jaundice

YES NO
- ☐ ☐ Kidney Disease
- ☐ ☐ Liver Disease
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Nervousness / Depression
- ☐ ☐ Pacemaker
- ☐ ☐ Prophylactic Antibiotics
- ☐ ☐ Periodontal Disease
- ☐ ☐ Radiation (Head / Neck)
- ☐ ☐ Respiratory Problems
- ☐ ☐ Rheumatic Fever

YES NO
- ☐ ☐ Seizures
- ☐ ☐ Stomach Problems
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Disease
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease

Women Only
- ☐ ☐ *Birth Control*
- ☐ ☐ *Nursing*
- ☐ ☐ *Pregnant*:

Delivery Date: _____

Do you have any of the following drug allergies?

YES NO
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Darvon
- ☐ ☐ Erythromycin

YES NO
- ☐ ☐ Latex
- ☐ ☐ Anesthetic
- ☐ ☐ Nitrous Oxide
- ☐ ☐ Sulfa

YES NO
- ☐ ☐ Percodan
- ☐ ☐ Penicillin
- ☐ ☐ Antibiotics
- ☐ ☐ Other

Please list other allergies.

_____

_____

_____

Please check any of the following drugs you have used at any time:

YES NO
- ☐ ☐ Fosamax
- ☐ ☐ Aredia

YES NO
- ☐ ☐ Didronel
- ☐ ☐ Actonel

YES NO
- ☐ ☐ Zometa
- ☐ ☐ Skelid

YES NO
- ☐ ☐ Boniva
- ☐ ☐ Bisphosphonates

Please list any medications you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Any illness not marked above? Please explain._____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify FOUNTAIN VALLEY DENTAL of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold FOUNTAIN VALLEY DENTAL or its employees liable in the event of death or injury.

Signature (Patient / Guardian) _____ Date: _____ Staff Signature:

Please check Yes or No for those that apply to you.

YES	NO	
☐	☐	Sensitivity to: Hot Cold Sweet
☐	☐	Chipped / Broken Teeth
☐	☐	Crooked or Tipped Teeth
☐	☐	Loose Teeth
☐	☐	Missing or Spaces Between Teeth
☐	☐	Catch Food Between Teeth
☐	☐	Dry Mouth or Constantly Thirsty
☐	☐	Smoke or Use Chewing Tobacco

YES	NO	
☐	☐	Bleeding, Swollen or Irritated Gums
☐	☐	Dissatisfied With Appearance of My Teeth
☐	☐	Frequent Headaches
☐	☐	Jaw Joint Pain
☐	☐	Grinding or Clenching Teeth
☐	☐	Uncomfortable or Uneven When I Bite My Teeth Together
☐	☐	Clicking or Popping of Jaw
☐	☐	Difficulty Opening or Chewin

Please check Yes or No if you have, or have had any of the following?

YES	NO	
☐	☐	Dentures or Partials
☐	☐	Braces or Clear Braces
☐	☐	Periodontal Disease or Gum Treatments
☐	☐	Fixed Bridge
☐	☐	Dental Implants
☐	☐	Crowns

YES	NO	
☐	☐	Veneers
☐	☐	Jaw Surgery
☐	☐	Root Canals
☐	☐	Sleep Apnea
☐	☐	C-PAP Machine or Oral Sleep Appliance
☐	☐	Fear or Anxiety About Dental Treatment

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

If I could change my smile, I would:

- ☐ Make My Teeth Whiter
- ☐ Make My Teeth Straighter
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Metal Fillings With Tooth Colored Fillings
- ☐ Fix My Teeth So I'm Not Embarrassed When I Smile
- ☐ Repair Chipped Teeth
- ☐ Replace Missing Teeth
- ☐ Replace Old Crowns That Look Dark or Don't Match
- ☐ Have a Smile Makeover
- ☐ Stop My Jaw From Hurting or Clicking

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No

Tell me how I can straighten my teeth in 6 months instead of 2 years and if I'm a candidate? ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Are you interested in sedation options? ☐ Yes ☐ No

If you could whiten your teeth for a investment anyone could afford, would you be interested? ☐ Yes ☐ No

Are you interested in whitening your teeth? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

(Staff Use Only)

Date Reviewed and Initials: _____ **Date Reviewed and Initials: _____** **Date Reviewed and Initials: _____**

Date Reviewed and Initials: _____ **Date Reviewed and Initials: _____** **Date Reviewed and Initials: _____**

RESERVED APPOINTMENT AGREEMENT

We make every effort to value your time and we schedule your appointment time just for you.

It is our philosophy to continue to put our patients first and to make your experience a positive one.

It is our policy for our patients to give us 2-business days notice if you need to change your appointment, and for you to call and speak directly with the staff members to best manage your appointment change.

Thank you for allowing us to take the time to review our reserved appointment agreement with you and please let us know if you have any questions. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

How would you like to be contacted?

_____I would like to be provided a courtesy confirmation by email _____

_____ I would like to be provided a courtesy confirmation by Text #_____

_____I would like to be provided a courtesy confirmation by phone #_____

_____ I will partner with **Fountain Valley Dental** by responding to messages provided by them with a confirmation either by text, email, or phone. This will support us with holding your reserved appointment time.

I have read the above reserved appointment agreement for **Fountain Valley Dental** and agree to partner with helping manage my scheduled appointment times.

Patient Signature: _____Date:_____

Front Office Administrator Signature: _____

FOUNTAIN VALLEY
DENTAL

AUTHORIZATION & DISCLOSURE (HIPAA)

CREDIT POLICY & FEES DISCLOSURE
ASSIGNMENT OF INSURANCE BENEFITS
AUTHORIZTION TO RELEASE INFORMATION
FINANCAIL RESPONSIBILITY

Truth-In-Lending Disclosure: In accordance with the Federal Truth-In-Lending Act, we are providing the following information about our credit and fee policy:

1. Patient Portion is due at the time of service.

2. Balances extended beyond 60 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%)

3. There will be a $75.00 fee charged for cancellations with less than 48-hour notice.

4. There will be a $25.00 fee charged for all returned checks.

Assignment of Insurance Benefits: I hereby authorize **FOUNTAIN VALLEY DENTAL** to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to **FOUNTAIN VALLEY DENTAL**.

Authorization to Release Information: I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

Financial Responsibility: I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental service received.

Authorization to Perform Procedures: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTANT THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

Print Full Name (Patient of Responsible Person, if patient is a minor) Date of Birth

Signature_____ Date_____

Authorization Valid Until Specifically Revoked in Writing

Ph: 503-759-3333 Fax: 503-759-3291 1400 Fountain Way Molalla, Or. 97038
Email: fountainvalleydental@gmail.com Web: fountainvalleydental.com

FOUNTAIN VALLEY
DENTAL

Consent to Share

If you would like us to discuss your financial account or treatment plan with someone other than yourself, please indicate them below. If there is any attempt made by anyone other than yourself to collect any information regarding your visits with us and their names are not stated below, we will **NOT** admit to knowing you as a patient of record with our office:

Release to: _____ Personal_____Financial_____

Release to: _____ Personal_____Financial_____

Signature: _____

(OFFICE USE)

If patient is unable to acknowledge receipt, staff member providing notice needs to complete this section

Privacy Notice was provided to

Name:_____Relation to Patient:_____Date:_____

Patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

_____

_____

_____

Signed: _____

Ph: 503-759-3333 Fax: 503-759-3291 1400 Fountain Way Molalla, Or. 97038
Email: fountainvalleydental@gmail.com Web: fountainvalleydental.com