Central Oregon Dental Center

MICHAEL R. HALL, D.D.S.

1563 NW Newport Avenue • Bend, Oregon 97701 • 389-0300 • Fax 330-9753

PATIENT INFORMATION

INFORMATION ABOUT YOU **DATE**_____

NAME_____ HOME PHONE #_____

ADDRESS_____ CELL PHONE #_____

CITY_____ STATE_____ ZIP_____ BIRTHDATE_____

SEX_____F_____M MINOR_____ SINGLE_____ MARRIED_____ DIVORCED_____ WIDOWED_____

EMPLOYER_____ SOCIAL SECURITY #_____

BUSINESS ADDRESS_____ BUSINESS PHONE #_____

CITY_____ STATE_____ ZIP_____ POSITION_____

IF MINOR: FATHER'S NAME_____ MOTHER'S NAME_____

IN CASE OF AN EMERGENCY, WHO MAY WE CONTACT?_____

PHONE #_____ RELATIONSHIP_____

WHO MAY WE THANK FOR REFERRING YOU?_____ Telephone Book_____ Other_____

PERSON RESPONSIBLE FOR ACCOUNT_____ HOME PHONE #_____

ADDRESS OF PERSON RESPONSIBLE FOR ACCOUNT_____

WE ARE HAPPY TO ASSIST YOU BY FILING YOUR INSURANCE CLAIM FOR YOU.
PLEASE COMPLETE THE FOLLOWING INFORMATION.

PRIMARY INSURANCE

NAME OF INSURED_____ BIRTHDATE OF INSURED_____

EMPLOYER OF INSURED_____ SOCIAL SECURITY # OF INSURED_____

INSURANCE COMPANY_____ GROUP #_____

INSURANCE ADDRESS_____ SUBSCRIBER I.D. #_____

INSURANCE PHONE #_____ RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE

NAME OF INSURED_____ BIRTHDATE OF INSURED_____

EMPLOYER OF INSURED_____ SOCIAL SECURITY # OF INSURED_____

INSURANCE COMPANY_____ GROUP #_____

INSURANCE ADDRESS_____ SUBSCRIBER I.D. #_____

INSURANCE PHONE #_____ RELATIONSHIP TO PATIENT_____

I hereby authorize payment directly to Michael R. Hall, D.D.S. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Michael R. Hall, D.D.S. and/or any provider or supplier of services in his office to release the information required to secure the payment. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ **Date**_____

Please complete reverse side

MEDICAL HISTORY

1. **PHYSICIAN'S NAME**_____ **PHONE #**_____

2. Have you been **under the care of a medical doctor** during the past two years? Yes No
   If yes, please state reason_____

3. Are you **currently taking any medications, drugs, or pills?** Yes No
   If yes, please list name and dosage_____

   _____

4. Are you aware of having an **allergic (or adverse reaction)** to any medication or substance? Yes No
   If yes, please list_____

5. Have you been a patient **in the hospital during the past five years**? Yes No
   If yes, please state reason_____

6. Indicate which of the following you have had, or have at present. **Circle "yes" or "no"** to each item.

Heart (Surgery, Disease, Attack)	yes	no	Ulcers	yes	no	Hepatitis (A, B or C)	yes	no
Chest Pain	yes	no	Diabetes	yes	no	Venereal Disease	yes	no
Congenital Heart Disease	yes	no	Thyroid Problems	yes	no	A.I.D.S.	yes	no
Heart Murmur	yes	no	Glaucoma	yes	no	H.I.V. Positive	yes	no
High Blood Pressure	yes	no	Contact Lenses	yes	no	Cold Sores/Fever Blisters	yes	no
Mitral Valve Prolapse	yes	no	Emphysema	yes	no	Blood Transfusion	yes	no
Artificial Heart Valve	yes	no	Chronic Cough	yes	no	Hemophilia	yes	no
Heart Pacemaker	yes	no	Tuberculosis	yes	no	Sickle Cell Disease	yes	no
Rheumatic Fever	yes	no	Asthma	yes	no	Bruise Easily	yes	no
Arthritis/Rheumatism	yes	no	Hay Fever	yes	no	Liver Disease	yes	no
Cortisone Medicine	yes	no	Latex Sensitivity	yes	no	Yellow Jaundice	yes	no
Swollen Ankles	yes	no	Allergies or Hives	yes	no	Neurological Disorders	yes	no
Stroke	yes	no	Sinus Trouble	yes	no	Epilepsy or Seizures	yes	no
Diet (Special/Restricted)	yes	no	Radiation Therapy	yes	no	Fainting or Dizzy Spells	yes	no
Artificial Joints (hip, knee, etc.)	yes	no	Chemotherapy	yes	no	Nervous/Anxious	yes	no
Kidney Trouble	yes	no	Tumors	yes	no	Psychiatric/Psychological Care	yes	no

7. Do you have or have you had **any disease, condition, or problem not listed**? Yes No
   If yes, please state_____
8. Have you **ever taken fen-phen or Redux**? Yes No
9. Do **you Smoke**? Yes No

10. **WOMEN:** Are you: **Pregnant?** Yes (months_____) No **Taking birth control pills?** Yes No
    Nursing? Yes No

DENTAL HISTORY

Former Dentist_____ Phone #_____ Last Dental Visit_____

Please check all that apply:

Bad Breath ❑	Loose Teeth or Broken Fillings ❑	Sensitivity to Sweets ❑
Bleeding Gums ❑	Orthodontic Treatment ❑	Sensitivity to Biting ❑
Blisters on Lips or Mouth ❑	Pain Around Ear ❑	Frequent Headaches ❑
Fingernail Biting ❑	Periodontal Treatment ❑	Jaw, Head or Neck Injuries ❑
Grinding Teeth ❑	Sensitivity to Cold ❑	Jaw Difficulty: Clicking and/or Pain ❑
Lip or Cheek Biting ❑	Sensitivity to Heat ❑	Tooth Pain ❑

- **I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.**
- **I hereby grant authority to Michael R. Hall, D.D.S. to administer any treatment and to administer such anesthetics, necessary diagnostic X-rays, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis treatment of my dental condition.**

Signature_____ **Date**_____

MICHAEL R. HALL, D.D.S.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

_____
(Or Signature of Legal Representative) Date

For Office Use Only

We attempted to obtain 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)

HEALTHCARE *COMPLIANCE* ASSOCIATES
90722 Hill Rd, Springfield, OR 97478 ∪ 541-345-3875 ∪ Fax: 541-345-3939

Central Oregon Dental Center
Office Financial Policy

Our primary mission is to deliver the finest, most cost effective dental care treatment available today. We feel a clear understanding of our office policy is important to our professional relationship. In order to assist you with your dental care investment, we are providing the following payment options.

Patients With Dental Insurance

Our office will gladly process your insurance claim, estimate your deductible and the portion not covered by your insurance to help you get the maximum benefit available from your insurance. Most dental plans do not cover 100% of the cost of treatment. Because of this, we ask our patients to pay their deductable and estimated percentage on the day service is rendered. We will estimate as closely as possible, however we can make no guarantee of any estimated or actual amounts.

> *Please note: Dental insurance coverage is a negotiated contractual agreement between the insurance company and you, the insured. The ultimate responsibility for all charges lies with you. Please ensure that you understand your policy coverage and limitations (including waiting periods). If, after 60 days the insurance company has not paid the claim, you will be responsible for the total balance.*

Patients Without Dental Insurance

Our office requires payment in full once treatment is completed. Treatment may be paid by one of the options listed below.

Payment Options

- **Cash, Check, Credit Card.** (Visa, Master Card, Discover, American Express)
  We are happy to offer 5% courtesy adjustment for all treatment if paid in full via cash or check on the day of service or before.
- **Care Credit:** Subject to credit approval, Care Credit offers patients a line of credit to cover your dental needs. In most situations, this is an interest free program for up to one year. You can apply with assistance at our office, or online at home.

Cancelation Policy

If you are unable to keep your appointment, we kindly request that you provide us with a minimum of 24 hour notice. For all late-cancel or no-show appointments, there will be a $25.00, per scheduled hour, broken appointment fee.

Non-Payment Procedure

Any balance over 30 days old may be subject to a 1% per month (12% per annum) finance charge. There will be a $25.00 charge on all returned checks.

I hereby authorize the doctor to release information necessary to secure payment. I have reviewed the above payment options and understand that I am financially responsible for all charges and for all services rendered on my behalf or my dependents.

Signature_____ Date _____

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Authorization to Release Records

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

Patients Full Name:_____Date of Birth:_____

Please indicate Records to be released:

Medical/Dental Records_____
Financial Records _____

We will not process until given complete Name, Address and Phone (Fax) Number.

Release to: Central Oregon Dental Center
Michael R Hall DDS
1563 NW Newport Ave
Bend, Or 97701
Email to: codental@bendbroadband.com

Release from: _____
_____
_____

_____ _____
Signature (Patient or Personal Representative) Date