**530 SE 4th Street**
**Hermiston, OR 97838**
**(541) 567-1693**

## OFFICE PAYMENT POLICIES

- The patient or guarantor of the account must provide all dental insurance information. The doctor is authorized to release information necessary to secure the payment of dental benefits.
- Any charges not covered by insurance are due at time of service.
- The dental provider may review individual financial situations and alternative means of payment may be discussed, prior to treatment.
- Our office accepts payments by means of CareCredit, Visa, Mastercard and Discover.
- Accounts over (90) days will be assessed a finance charge of 1.5% of the balance to defray the cost of repeat statements that need to be sent.
- If it becomes necessary to effect collections of amount the undersigned agrees to pay for all cost and expenses, including reasonable attorney fees.
- A $50.00 fee will be charged for failure to give 24-hour cancellation notice for missed appointments.

Signature_______________________________Date_______________________

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# MEDICAL HISTORY

*So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential.*

PATIENT'S NAME: ______________________ DOB: ____________

Have you been under the care of a medical doctor during the past two years? ........ Yes No

If yes, for what? ______________________

Physician's Name ______________ Telephone ______________

Address ______________ City ______________ State ________ Zip ________

Are you currently taking any medications, drugs or pills? ........ Yes No

If yes, please list name and dosage: ______________________

______________________

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ........ Yes No

If yes, please list: ______________________

Circle Yes or No to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition .................. Yes / No
Heart Attack .................. Yes / No
Heart Surgery .................. Yes / No
Chest Pain (Angina) .................. Yes / No
Congenital Heart Disease ..... Yes / No
Stroke .................. Yes / No
High Blood Pressure .................. Yes / No
Mitral Valve Prolapse .................. Yes / No
Artificial Heart Valve .................. Yes / No
Rheumatic Fever .................. Yes / No
Heart Murmur .................. Yes / No
Heart Pacemaker .................. Yes / No
Anemia .................. Yes / No
Hemophilia .................. Yes / No
Ulcers .................. Yes / No
Alcoholism .................. Yes / No
Drug Addiction .................. Yes / No
Diabetes .................. Yes / No
Family History of Diabetes ..... Yes / No

Contact Lenses .................. Yes / No
Glaucoma .................. Yes / No
Bruise Easily .................. Yes / No
Emphysema .................. Yes / No
Chronic Cough .................. Yes / No
Tuberculosis (T.B.) .................. Yes / No
Asthma .................. Yes / No
Hay Fever .................. Yes / No
Sinus Trouble .................. Yes / No
Allergies or Hives .................. Yes / No
Liver Disease .................. Yes / No
Hepatitis Type ____ .................. Yes / No
Yellow Jaundice .................. Yes / No
AIDS .................. Yes / No
HIV Positive .................. Yes / No
Venereal Disease .................. Yes / No
Cold Sores/Fever Blisters ..... Yes / No
Blood Transfusion .................. Yes / No
Thyroid Problems .................. Yes / No
Swollen Ankles .................. Yes / No

Cortisone Medicine .................. Yes / No
Arthritis/Rheumatism .................. Yes / No
Fen-Phen or Redox.................. Yes / No
Special or Restricted Diet .................. Yes / No
Latex Sensitivity .................. Yes / No
Cancer .................. Yes / No
Tumors .................. Yes / No
Chemotherapy .................. Yes / No
Radiation Therapy .................. Yes / No
Neurological Disorders .................. Yes / No
Nervous/Anxious .................. Yes / No
Epilepsy or Seizures .................. Yes / No
Fainting or Dizzy Spells .................. Yes / No
Psychiatric/Psychological Care .. Yes / No
Kidney Trouble .................. Yes / No
Artificial Joints or Heart Valves... Yes / No
Sickle Cell Disease .................. Yes / No
Osteoporosis.................. Yes / No
Bone Disease or Bone Cancer... Yes / No

Do you have or have you had any disease, condition or problem not listed ........ Yes No

If yes, please list: ______________________

Have you ever had prolonged or unusual bleeding? ........ Yes No

Are you taking or have you ever taken any of the following medications: Aredia (pamidronate), Zometa (zolendronic acid), Bonefos (clodronate), Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), Skelid (tiludronate), Didronel (etidronate)..... Yes No

Have you ever had a reaction to a local anesthetic? ........ Yes No

Do you use more than two pillows to sleep? ........ Yes No

Do you experience frequent thirst, frequent eating or frequent urination? ........ Yes No

**Women:** Are you pregnant?...Yes No If yes, due date: __________ Nursing?...Yes No Taking birth control pills?...Yes No

(Please complete the other side)

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# PATIENT REGISTRATION

*Please complete the following confidential information*

**PATIENT INFORMATION** ACCOUNT#__________

NAME ________________________________________________
(First) (Middle) (Last)

WHO MAY WE THANK FOR REFERRING YOU TO US? ____________________

SOCIAL SECURITY # __________________ DATE OF BIRTH ______________

BILLING ADDRESS ________________________________________________

CITY __________________ STATE ___ ZIP __________ CELL PHONE __________ HOME PHONE __________

EMPLOYER: __________________________ E-MAIL __________________________

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): ☐ Self ☐ Spouse ☐ Child ☐ Other

**PRIMARY DENTAL INSURANCE INFORMATION:**

NAME OF INSURANCE COMPANY: __________________________ GROUP/POLICY # __________

NAME OF SUBSCRIBER __________________________ SOCIAL SECURITY # __________
(First) (Middle) (Last)

STREET ADDRESS ________________________________________________

CITY __________________ STATE __________ ZIP __________ HOME PHONE __________

DATE OF BIRTH __________ MARITAL STATUS: ☐ Married ☐ Single ☐ Other WORK PHONE __________ EXT ______

EMPLOYER __________________________ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

**SECONDARY DENTAL INSURANCE INFORMATION:**

NAME OF INSURANCE COMPANY: __________________________ GROUP/POLICY # __________

NAME OF SUBSCRIBER __________________________ SOCIAL SECURITY # __________
(First) (Middle) (Last)

DATE OF BIRTH __________ MARITAL STATUS: ☐ Married ☐ Single ☐ Other WORK PHONE __________ EXT ______

EMPLOYER __________________________ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

**CONSENT:**

1. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** By signing below I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.
2. I hereby authorize Dr. Greg B. Jones or designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by Dr. Greg B. Jones to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Greg B. Jones to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.
3. **I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Fourth Street Family Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the Doctor has a contractual agreement with my plan prohibiting all or a portion of such charges.**
4. By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above items.**

**Patient/Guardian's Signature** __________________________ **Date** __________

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# DENTAL HISTORY

PREVIOUS DENTIST ______________________________

DATE OF LAST DENTAL VISIT ____________ LAST DENTAL CLEANING ____________ LAST FULL MOUTH X-RAYS ____________

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? ____Seldom ____ Less than annually ____ Annually ____ Twice Annually or More

HOW OFTEN DO YOU BRUSH YOU TEETH? ______________ HOW OFTEN DO YOU FLOSS? ______________

WHAT OTHER DENTAL AIDS DO YOU USE? (Mouthrinse, toothpick, etc.) ______________________

Have you ever had:

- Periodontal Treatment (deep cleaning or gum surgery)? ........... Yes No.......... If yes, when? ______________
- Oral Surgery (tooth removal)? ........................................... Yes No
- Orthodontic Treatment (braces)? ........................................ Yes No ......... If yes, when? ______________
- Your teeth ground or the bite adjusted? ................................ Yes No
- A bite plate or mouth guard? ............................................. Yes No

Do you smoke or chew tobacco? ..................................................... Yes No.......... If yes, how much? ______________

Do you clench or grind your teeth while awake or asleep? ......................Yes No

Has any of your family members experienced periodontal disease (such as gum disease or gingivitis)? ................................ Yes No.......... If yes, which family members? ______________

Have you noticed any loose teeth or a change in your bite? ....................Yes No ______________

Do you mouth-breathe while awake or asleep? ..................................Yes No

Does food tend to become caught in between your teeth? ......................Yes No.......... If yes, where? ______________

Do you have tired jaws, especially in the morning?.............................. Yes No ______________

Do you regularly experience clicking, popping or pain in the jaw joints?......Yes No

Do you have difficulty in opening or closing your mouth? ........................Yes No

Would you like to keep all of your teeth all of your life? ......................... Yes No

Do you feel nervous about having dental treatment? ............................ Yes No.......... If yes, what is your main concern? ______________

______________

Have you ever had an upsetting dental experience? ............................ Yes No.......... If yes, please describe: ______________

______________

Have you ever been told you need to take premedication prior to dental treatment? ______________

Please explain anything else about having dental treatment that you would like us to know? ______________

______________________________

______________________________

*I understand that my medical and dental histories are 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, Dr. Greg B. Jones has my permission to ask the respective health care provider or agency, who may release such information to Dr. Greg B. Jones*
*I will notify Dr. Greg B. Jones of any change in my health and/or medication(s).*

**Patient/Guardian's Signature** ______________________ **Date** ______________

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