If you would like to get a head start on your paperwork,

please print out and complete the forms in this packet, and bring them with you to your appointment.

We're looking forward to seeing you!

CHINOOK FALLS DENTAL CLINIC, P.C.
36840 SE INDUSTRIAL WAY • SANDY, OR 97055
JIM FLERCHINGER, D.D.S. 503-668-8301

NEW PATIENT QUESTIONNAIRE

- Previous Dentist Name & Phone #: _____

(If you would like to call your previous dental office, please ask for date of last x-rays & perio chart. You may request that they be emailed to us at: contactus@chinookfallsdental.com)

Last X-Rays:	BW: _____	FMX: _____
Sealants:	Freq: _____	Age Limit: _____
Fluoride:	Freq: _____	Age Limit: _____

- Last time you had your teeth cleaned: _____

- Have you ever needed to be medicated prior to having your teeth cleaned? __
  - If yes, reason and are you allergic to any medications? _____
    _____

- Have you ever been told you need perio scaling? _____

- Do you have dental insurance?
  - Group/Employer name: _____
  - Group number: _____
  - Subscriber/Employee Name/DOB: _____
  - ID #: _____
  - Insurance Carrier/Company Name: _____

- **** Please arrive 10 minutes before your appointment time and bring a list of any prescription medications you are taking. ☐

TIME 4:42 PM DATE

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Emergency Contact:

Contact Relationship:

Emer Contact Phone:

Spouse Name:

Primary Insurance Information

Name of Insured: Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Chinook Falls Dental Clinic PC Medical History(Current 7-14)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interaction with the dental care you will receive. Thank you for answering the following:

Are you under a physician's care now?	Yes	No	If yes
Are you pregnant, trying to get pregnant or think you may be pregnant?	Yes	No	
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Do you use medical marijuana or any controlled substances?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you taking a blood thinner? (e.g., Warfarin, Coumadin, etc?)	Yes	No	If yes
If yes, do you know your INR?	Yes	No	If yes
Are you taking any prescription or non prescription medication, including vitamins?	Yes	No	If yes

Medications continued:

Do you use tobacco or nicotine products?

Cigarettes	Yes	No	E-Cigarettes	Yes	No	Chewing Tobacco	Yes	No	Cigars or Pipes	Yes	No

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other Allergy?	Yes	No	If yes

Have you been diagnosed with Diabetes?	Yes	No	
If yes, do you know your most recent A1C/eAG #	Yes	No	If yes
Preprandial	Yes	No	If yes
Postprandial	Yes	No	If yes

Do you have an artificial joint?

Artificial Joint	Yes	No	Has doctor recommended pre-medication?	Yes	No

Have you been diagnosed with cancer?

Cancer	Yes	No	Chemotherapy	Yes	No	Radiation Treatment	Yes	No

Have you been diagnosed with Heart problems, or have you had any of the following?

Angina	Yes	No	Heart Murmer	Yes	No	Mitral Valve Prolapse	Yes	No	Artificial Heart Valve	Yes	No
High/Low Blood Pressure	Yes	No	Pacemaker	Yes	No	Bacterial Endocarditis	Yes	No	Heart Trouble/Disease	Yes	No
Rheumatic Fever	Yes	No	Heart Attack/Failure	Yes	No	Irregular Heartbeat	Yes	No	Scarlet Fever	Yes	No

Have you been diagnosed with Lung complications?

Asthma	Yes	No	Emphysema	Yes	No	Tuberculosis	Yes	No

Have you been diagnosed with Liver complications?

Cirrhosis	Yes	No	Hepatitis A	Yes	No	Hepatitis B or C	Yes	No

Have you been diagnosed with a neurological disorder?

Alzheimer's Disease	Yes	No	Parkinson's Disease	Yes	No	Epilepsy or Seizures	Yes	No	Psychiatric Care	Yes	No

Have you experienced any of the following conditions?

Anaphylaxis	Yes	No	Breathing Problems	Yes	No	Bruise Easily	Yes	No	Cold Sores/Fever Blister	Yes	No
Dry Mouth	Yes	No	Drug Addiction	Yes	No	Easily Winded	Yes	No	Excessive Bleeding	Yes	No
Excessive Thirst	Yes	No	Fainting Spells	Yes	No	Frequent Cough	Yes	No	Frequent Diarrhea	Yes	No
Frequent Headaches	Yes	No	Hay Fever	Yes	No	Hives or Rash	Yes	No	Hypoglycemia	Yes	No
Pain in Jaw Joints	Yes	No	Recent Weight Loss	Yes	No	Sinus Trouble	Yes	No	Sleep Apnea	Yes	No
Swelling of Limbs	Yes	No									

Have you ever been diagnosed with, or experienced, any of the following?

AIDS/HIV positive	Yes	No	Arthritis/Gout	Yes	No	Blood Clots	Yes	No	GERD	Yes	No
Glaucoma	Yes	No	Herpes/HSV-2	Yes	No	High Cholesterol	Yes	No	Intestinal Disease	Yes	No
Organ Transplant	Yes	No	Osteoporosis	Yes	No	Parathyroid Disease	Yes	No	Peripheral Neuropathy	Yes	No
Shingles	Yes	No	Stroke	Yes	No	Thyroid Disease	Yes	No	Tumors or Growths	Yes	No
Ulcers	Yes	No	Venereal Disease/STD	Yes	No						

Have you had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

CHINOOK FALLS DENTAL CLINIC, PC

36840 SE Industrial Way, Sandy OR 97055
503-668-8301

FINANCIAL ARRANGEMENTS

As a courtesy, we are happy to assist you by billing your insurance company for you. Please remember that your insurance co-pay and/or patient responsibility portion are ***due at time of service.***

If you have no insurance, we require payment in full at time of service.
We do offer a 10% discount if you pay in full at time of service with CASH, PERSONAL CHECK or MONEY ORDER.

If you prefer to make payments, we also accept VISA and MASTERCARD.
Interest-free or extended payment plans are available through CareCredit
(a division of GE Consumer Finance, subject to credit approval).

Finance charge of 1.5% per month will be charged on any balance unpaid after 90 days.
Minimum charge $2.50 Annual percentage rate 18%

AUTHORIZATION AND RELEASE

I authorize the clinic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to insurance companies and/or healthcare practitioners.

I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and for my dependents.

X_____ Date_____
Signature of patient (or parent, if minor)

Thanks so much for choosing our office!

CHINOOK FALLS DENTAL CLINIC, P.C.
36840 SE INDUSTRIAL WAY • SANDY, OR 97055
JIM FLERCHINGER, D.D.S. 503-668-8301

Failure to Keep Appointment Policy
("No Show")

We are happy to do all we can to help patients make it to their appointments. We will try to confirm appointments two business days before the scheduled appointment.

Despite our best efforts to assist patients, "No Shows" still occur. This is lost time for our office. Other patients are waiting for appointments. Therefore, please be aware that there is a $50 charge for "No Show" appointments. This will be billed directly to you and will **not** be covered by insurance. Signing this form indicates that you understand the reason for the charge and that payment is your responsibility. We require two business days notice to cancel your appointment to avoid this charge.

Frequent failure to keep scheduled appointments confirms to us that the patient - office relationship is not working. After multiple such events, we may send a letter to transfer the patient out of the practice. That letter is a 30-day written notice during which time we will see the patient for **emergency care** only.

Being fifteen (15) minutes or more late without phoning the office is considered a "No Show."

This is to acknowledge that I have been made aware of the Failure to Keep Appointment Policy (aka: Cancelation Policy) for Chinook Falls Dental Clinic, PC.

Print Patient Name: X_____ Date: _____

Signature: X_____ Date: _____
(Patient or Responsible Party)

Chinook Falls Dental Clinic, PC

ACKNOWLEDGEMENT 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.

_____

Patient Name

_____

Patient Signature (or Parent/Guardian if minor)

_____

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)

_____

_____

_____

Chinook Falls Dental Clinic, PC

NOTICE OF PRIVACY PRACTICES

Effective Date: October 1, 2013

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Debbie Flerchinger Telephone: (503) 668 - 8301 Fax: (_____) _____-_____

Email: Debbie@ChinookFallsDental.com Address: 36840 Industrial Way, Ste. A, Sandy, OR 97055

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.