

DENTAL CARE OF SHERWOOD INC.

Nicholas I. Methven, D.D.S.
21000 SW Dahlke Lane
Sherwood, OR 97140

DATE: _____ HOME PHONE: _____ WORK PHONE: _____

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CELL PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____ E-MAIL ADDRESS: _____

SEX: MALE FEMALE AGE: _____ BIRTHDATE: _____ MARITAL STATUS: _____

OCCUPATION: _____ EMPLOYER: _____

BUSINESS ADDRESS: _____

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU _____ PHONE: _____

WHO IS RESPONSIBLE FOR ACCOUNT? _____ DRIVER'S LIC.# _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ARE YOU COVERED BY ONE OR MORE INSURANCE PLANS? YES NO

PRIMARY INSURANCE

SUBSCRIBER'S NAME: _____ SOCIAL SECURITY #: _____

RELATION TO PATIENT: _____ BIRTHDATE: _____

EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ INSURANCE PHONE: _____

GROUP #: _____

SECONDARY INSURANCE

SUBSCRIBER'S NAME: _____ SOCIAL SECURITY #: _____

RELATION TO PATIENT: _____ BIRTHDATE: _____

EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ INSURANCE PHONE: _____

GROUP #: _____

I HAVE READ AND UNDERSTAND THE GENERAL POLICIES FOR DENTAL CARE OF SHERWOOD. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE, AND I AGREE TO COMPLY WITH THE POLICIES.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE: _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT: _____

PREVIOUS DENTIST: _____ PHONE NUMBER: _____

DATE OF LAST DENTAL CARE: _____ LAST DENTAL X-RAYS: _____

PLEASE CHECK IF YOU HAVE ANY CONCERNS:

- Bad Breath
- Grinding Teeth
- Sensitivity to Cold
- Bleeding Gums
- Loose Teeth
- Sensitivity to Heat
- Clicking or Popping Jaw
- Broken Teeth
- Sensitivity when Biting
- Food Collection Between Teeth
- Periodontal Treatment
- Sores in your Mouth
- Fear of Dental Treatment
- Lost or Broken Fillings

HOW OFTEN DO YOU FLOSS? _____ HOW OFTEN DO YOU BRUSH? _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ DATE OF LAST VISIT: _____

PREVIOUS HOSPITALIZATIONS, ILLNESSES, OR OPERATIONS (Please describe and give approximate date.) _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO IF YES, APPROX. DATE: _____

WOMEN: NURSING? YES NO BIRTH CONTROL: YES

PLEASE CHECK () IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- AIDS
- Cortisone Treatments
- Hepatitis
- Respiratory Disease
- Anemia
- Cough, Persistent
- High Blood Pressure
- Rheumatic Fever
- Arthritis, Rheumatism
- Diabetes
- HIV Positive
- Scarlet Fever
- Artificial Heart Valves
- Epilepsy
- Jaw Pain
- Stroke
- Artificial Joints
- Fainting
- Kidney Disease
- Thyroid Problem
- Asthma
- Glaucoma
- Latex Allergy
- Tobacco Habit
- Back Problems
- Headaches
- Liver Disease
- Tonsillitis
- Blood Disease
- Heart Murmur
- Mitral Value Prolapse
- Tuberculosis
- Cancer
- Heart Problems
- Nervous Problems
- Ulcer
- Chemical Dependency
- Describe _____
- Pacemaker
- OTHER: Pregnant or breast-feeding (currently)
- Chemotherapy
- High Cholesterol
- Psychiatric Care
- Radiation Treatment
- Circulatory Problems
- Hemophilia

Dr.'s Notes: _____

LIST ANY MEDICATIONS YOU ARE TAKING: _____

ANY ALLERGIES (Including Medications): _____

TREATMENT CONSENT AND FINANCIAL AGREEMENT

I, the undersigned, consent to treatment which is advisable and agreeable to both myself and the Dentist with the realization that certain rare and infrequent complications may occur. These may include the following:

- 1) Injury to adjacent restorations, teeth, or other tissue.
- 2) Trismus: prolonged stiffness of muscles.
- 3) Fistula: Small openings between the mouth and sinus following the removal of upper teeth.
- 4) Fracture of bone.
- 5) Paresthesia: Nerve involvement that may result in numbness of the lip, chin, teeth, gums, or tongue.
- 6) Dry Socket

I understand that there can be no guarantee as to any treatment result or cure. I realize that additional therapeutic procedures may become apparent during treatment and allow the Dentist to utilize his judgement. I also understand that payment is due at the time of service. I realize that if insurance is involved, I am responsible for any portion my insurance does not cover or if insurance does not pay in a timely manner. I understand that this dental office does not guarantee payment by my insurance and that any covered amounts given are an **estimates only**. I am responsible for any remaining balance after insurance payment. In the event that a collection agency is needed to recover any debt, I am aware that an additional collection charge may be added to my account. I also understand that all accounts over 60 days will accrue Finance Charges. **Please note, we are not a preferred provider for any dental insurance companies.**

Signed: _____ Date: _____
(Patient or person authorized to consent)

PLEASE SEE THE ATTACHED PAGE FOR DENTAL INSURANCE QUESTIONS, THANK YOU.

IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding your dental insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different employers. Each employer pays an insurance premium for specific coverage that fits the employer's budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles, and required amounts that are due to the dental office.

Our office will provide you with the following courtesy services:

- Filing your insurance claim within 24 hours of your visit and requesting payment of your benefit to our office.
- Researching your dental plan to advise you of estimated benefits available to you.
- Re-filing your insurance claim a second time if payment is not received within 60 days.
- Our office follows the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the subscriber of the dental policy and/or our patient:

- Your estimated portion is due at the time of service; this portion is the estimated portion based upon the information that your insurance provides our office. You are responsible for any fees that the insurance does not cover.
- Understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
- Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called "usual & customary") and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
- Taking responsibility for payment if the insurance does not pay our office within 75 days.
- Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

I hereby authorize Dental Care of Sherwood to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dental Care of Sherwood. I understand I am fully responsible for any unpaid balance.

Signature of patient or responsible party _____

Date: _____