



Dental Care

Welcome

Quality Care for Cosmetic and Sedation Dentistry

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A very warm welcome to you! The entire team would like to thank you for selecting our office to care for your dental needs. Our goals are to provide each patient with the highest quality dental care in a gentle, efficient, and pleasant manner, and to strongly encourage prevention of future dental problems.

- We'll put your needs and wishes first and advise you on the best long-term preventive plan for healthy teeth.
- We use only the best material and labs. All instruments go through a steam autoclave for sterilization. All services are rendered with the latest techniques available.
- We base our measure of success on the quality of the relationship we have with each patient, not just on the quality of the dental service we provide.
- We take special interest in helping the fearful or sensitive patient, who may have had difficulty before, and may be avoiding dental treatment because he or she has been hurt elsewhere.

Should you have any questions, please do not hesitate to confide in us regarding any worries you have about your oral health. We'll always take time to answer your questions and give you every reason to smile. That's why we're here.

We have someone on call 24 hours a day, so if you need us – we're here for you. Enclosed are the new patient forms, please fill them out and bring them with you to your appointment.

We look forward to meeting and getting to know you.

The Staff of Delta Oaks Dental Care

2710 Delta Oaks Drive

♦ Eugene, OR 97408

♦ (541) 484-9106



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Welcome

Quality Care for Cosmetic and Sedation Dentistry

PATIENT INFORMATION

Today's Date: _____

Name: _____

Birthdate: ___/___/___ Soc. Sec. #: ___ - ___ - ___

Address: _____

City/State: _____ Zip: _____

Phone: Hm:() ___ - ___ Wk :() ___ - ___

Cell:() ___ - ___

Employer: _____

RESPONSIBLE PARTY (IF, Other than Patient)

Name: _____

Birthdate: ___/___/___ Soc. Sec. #: ___ - ___ - ___

Address: _____

City/State: _____ Zip: _____

Phone: Hm:() ___ - ___ Wk :() ___ - ___

Cell:() ___ - ___

Employer: _____

Preferred Method of Receiving Appointment Confirmations

PHONE TEXT EMAIL: _____
(Email Address)

Preferred Pharmacy:

PRIMARY INSURANCE INFORMATION

SUBSCRIBER: Self Other (Fill out below)

Name: _____

Birthdate: _____ Relation to Patient: _____

Ins. Company: _____

Group #: _____ Phone #: _____

Address: _____

City/State: _____ Zip: _____

Employer: _____

Soc. Sec. # / ID#: _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER: Self Other (Fill out below)

Name: _____

Birthdate: _____ Relation to Patient: _____

Ins. Company: _____

Group #: _____ Phone #: _____

Address: _____

City/State: _____ Zip: _____

Employer: _____

Soc. Sec. # / ID#: _____

Spouse's Name: _____ **Employer:** _____ **Wk #:()** ___ - ___

Emergency Contact: _____ **Phone#:()** ___ - ___

Is another member of your family or relative a patient at our office:

Name: _____ **Relationship:** _____

How did you hear about our office? _____

PATIENT CONSENT FOR TREATMENT

- 1) I authorize the doctor / staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
- 2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- 3) I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

MEDICARE

I understand that Delta Oaks Dental Care has **opted out of Medicare**. This should have little or no effect on me since Medicare does not cover most dental services. By opting out, neither I nor Delta Oaks Dental can bill Medicare for any dental services rendered.

INSURANCE

Insurance will be billed according to the billing / payment guideline of my primary insurance. I understand that as a courtesy, Delta Oaks Dental will submit insurance claims on my behalf; however, they do not guarantee any payment of benefits.

If my insurance coverage does not cover the estimated amount, I will be responsible for payment in full. Additionally, if I fail to provide accurate insurance information to the business office within 30 days of the date of service, I will be expected to pay the account in full and get reimbursed from my insurance carrier.

Deductibles, co-insurance, non-covered services (including pre-existing conditions), and services denied due to incorrect insurance eligibility are my responsibility.

I authorize my insurance company(s) to pay Delta Oaks Dental Care all insurance benefits for dental services rendered to me or members of my family.

FINANCIAL AGREEMENT

I agree to be responsible for payment of all services rendered on my behalf or my dependants. **I understand that payment is due at the time of service unless other arrangements have been made.** In the event that payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18% APR) may be added to my account.

Additional Charges:

- I know that **I must call to cancel an appointment at least 24 hours** (1 day) before the time of the appointment. If I do not cancel and do not show up a charge will be assessed for time reserved and future appointments will need to be pre-paid.
- I understand that delinquent accounts will be assigned to a credit reporting collection agency and I will be charged a **\$100** collection fee.

HIPPA

Release of Information:

- I give consent to the doctor's or designated staff's use at Delta Oaks Dental Care to disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, referral to other healthcare professionals and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
- I would like a copy of this office's "Notice of Privacy Practices"? Yes No

I acknowledge that I read English and have read and understood the contents of this form. I agree to adhere to the Above policies of Delta Oaks Dental Care

Print Patient Name

Signature of Patient, Parent or Guardian

Date

DENTAL HISTORY - INITIAL OFFICE VISIT

So that we may provide you with the best possible care please complete both sides of this Medical / Dental history form. All information is completely confidential

Patient Name: _____ Date: _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last visit? _____

Previous Dentist name: _____ Telephone _____

CHIEF CONCERN: _____

<p>Are any of your teeth sensitive to:</p> <p>Hot or Cold? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Biting or chewing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you noticed any mouth odors or bad tastes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your gums bleed or hurt? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does food tend to become caught in between your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you:</p> <p>Clench or grind your teeth while awake or asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have Soreness in your jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have tired jaws, especially in the morning? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Snoring / sleeping disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Smoke/chew tobacco or use other tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Have you ever had:</p> <p>Orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Oral Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Periodontal treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Your teeth ground or the bite adjusted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A bite plate or mouth guard? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you feel nervous about having dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

MEDICAL HISTORY

Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If answering yes, to any of the following questions, please explain in space provided.

- Are you undergoing Medical treatment at this time? Yes No _____
- Have you ever been hospitalized or had a major operation? Yes No _____
- Have you ever had a serious head or neck injury? Yes No _____
- Are you taking any medications, pills, or drugs? Yes No _____
- Do you take or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____
- Are you being treated for Osteoporosis? Yes No _____
- Are you taking Fosomax, Boniva or Actinal? Yes No _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

Aids/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Meds	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
What Type:	_____						
Date Placed:	_____						
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/ Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble / Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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.

Printed Patient Name

Signature of Patient, Parent or Guardian

Date