HEALTH HISTORY

MID-VALLEY DENTAL ASSOCIATES Geoffrey A. Berg, DMD Daniel H. Reynolds, DMD

2825 Willetta Street SW Albany, OR 97321

Name: __ Birthdate

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Birthdate:	Age:			(541) 928-2	301	
DENTAL HISTORY						
Reason for today's visit:						
Former Dentist:		City: _				
Date of last dental visit:	Da	ate of last dental x-ra	ys:			
Please check if you have or h	nave had any of the following:					
☐ Bad breath ☐ Bleeding gums ☐ Grinding teeth ☐ Pain in mouth	☐ Clicking or popping jaw ☐ So ☐ Loose teeth or broken fillings ☐ So ☐ Food collection between teeth ☐ So		Ser Ser	eriodontal treatment ensitivity to sweets ensitivity to hot/cold ensitivity when biting		
Are you satisfied with the appe Please rate your smile:	earance of your teeth? 0 1 2 3	4 5		7 8	9	10
•	0 1 2 3	1 3	Ü	, 0		10
MEDICAL HISTORY						
Physicians Name:		_ Date of last physic	al:			
Have you had any serious illne	ess or operations? yes no	If yes, describe: _				
For female patients only: Are you pregnant? yes no	o Nursing? yes no	Taking birth c	ontrol pills?	yes no		
Do you require antibiotics pric	or to dental treatment? yes n	0				
Please check if you have or h	nave had any of the following:					
☐ AIDS ☐ Alzheimers, Dementia, memory loss ☐ Anemia ☐ Artificial joints ☐ Artificial heart valve ☐ Asthma ☐ Back problems ☐ Blood disease ☐ Cancer ☐ Chemical dependency ☐ Chemotherapy ☐ Other (describe):	Circulatory problems Cortisone treatments Cough, persistent Diabetes Epilepsy Fainting Fibromyalgia Glaucoma Headaches Heart murmur Heart problems Hemophilia	Hepatitis High blood High choles HIV Kidney dise Latex allerg Liver diseas Mitral valve Nervous pro Osteoporos Pacemaker Parkinson's	ase y e prolapse oblems is disease	Resp Radi Rheu Shor Skin Strol Thyr Toba Tons Ulce	roid prob acco habi sillitis erculosis	isease atment ver preath
MEDICATIONS:						
ALLERGIES:						
By signing, I acknowledge that	I have read and answered the abo	ve questions to the b	est of my kr	owledge.		

Signature of patient (or of parent or guardian if patient is a minor)

Date

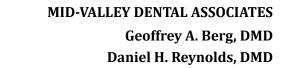


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PATIENT INFORMATION

GUARANTOR INFORMATION (Responsible person for account - parent or guardian if patient is a minor)

Legal name:	Preferred Name:	Birthda	te:
Address:	City:	State:	_ Zip:
Home phone:	Mobile:	Work:	
Email:	Sc	ocial Security No:	
Employer:	Who should we thank for referring you to us?		
If married: Spouse's Name	Sp. DOB:	Sp. Employer	
PATIENT INFORMATION (Compl	ete if patient is a minor. If the patient is	the guarantor, you may sk	ip this section)
Legal name:	Preferred Name:	Birthdate	9:
Address:	City:	State:	_ Zip:
Home phone:	Mobile:	Work:	
Relationship to guarantor:	Social Securit	ty No:	
INSURANCE INFORMATION			
Policy holder name:	Birthdate:	Phone:	
Address:	City:	State:	_ Zip:
Employer:	Insurance carrier:	:	
Subscriber ID No:	Group No:	Insurance Co. Phone:	
Insurance Co. Address:	City:	State:	_ Zip:
If you have secondary dental insu	rance coverage, please complete the sec	ction below	
Policy holder name:	Birthdate:	Phone:	
Address:	City:	State:	_ Zip:
Insurance carrier:	Subscriber ID No:	Group N	0:
Insurance Co. Address:		Phone:	
EMERGENCY CONTACT			
Name:	Relationship to patient:	Phone:	
AUTHORIZATION & RELEASE			
my insurance company to pay directly to	read and answered the above questions to the dentist, insurance benefits otherwise payment of benefits. I understand that I am finansignature on all insurance submissions.	able to me. I authorize the doct	or to release all
Signature of patient (or of parent or gu	nardian if patient is a minor) Da	nte	





FINANCIAL AGREEMENT & POLICIES

This statement is to inform you of our financial policy. We are committed to providing you with the finest quality care using only the best material and technology available in the market today. All charges you incur are your responsibility regardless of your insurance coverage.

Insurance coverage is a valuable asset in restoring and maintaining good oral health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. We may also be able to determine benefits prior to treatment, which provides you with important deductible and co-payment information. Our relationship is with you as our patient, not the insurance company. Our office is not a party to that contract and final responsibility of payment is yours. As a courtesy to you, we will help you process your insurance claims. If there is no payment from the insurance company within sixty (60) days, you will be expected to pay the balance in full.

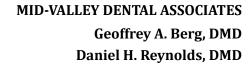
Your portion of the payment is due at the time that services are rendered. We accept cash, money orders, personal checks, Visa, MasterCard, American Express and Discover. We also offer no interest and low interest extended payment plans through Care Credit.

Returned checks for any reason, will be assessed a processing fee of \$25.00. Balances older than 60 days are subject to collection fees and finance charges at the rate of 18% annually. NOTE: If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and collection costs.

Missed appointments without 24 hours notice are subject to a charge of \$50.00.

I have read the above statement of the Financial Agreement and Policies, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account.

Signature	Date
0	





HIPAA - ACKNOWLEDGEMENT OF RECEIPT Notice of Privacy Practices

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. If you have any questions or concerns regarding the notice, please ask to speak with our HIPAA Compliance Manager.

Printed Patient Name:	
I hereby acknowledge that I have reviewed the HIPAA	Notice of Privacy Practices document.
Signature of patient or patient's representative	 Date
Printed name of patient or patient's representative	
Relationship to patient	
For Program U	se Only
We attempted to obtain written acknowledgement of receipt of or could not be obtained due to the following:	ur Notice of Privacy Practices, but acknowledgement
☐ Individual refused to sign	
Communication barriers prohibited obtaining acknowled	dgement
☐ An emergency situation prevented us from obtaining act	knowledgement
Other (please specify)	