

# HEALTH HISTORY

MID-VALLEY DENTAL ASSOCIATES  
Taylor C. Bennion, DMD

2811 Main Street  
Philomath, OR 97370  
(541) 929-5227



Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ City: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

### Please check if you have or have had any of the following:

- |                                         |                                                         |                                                  |
|-----------------------------------------|---------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Bad breath     | <input type="checkbox"/> Sores or growths in mouth      | <input type="checkbox"/> Periodontal treatment   |
| <input type="checkbox"/> Bleeding gums  | <input type="checkbox"/> Clicking or popping jaw        | <input type="checkbox"/> Sensitivity to sweets   |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot/cold |
| <input type="checkbox"/> Pain in mouth  | <input type="checkbox"/> Food collection between teeth  | <input type="checkbox"/> Sensitivity when biting |

Are you satisfied with the appearance of your teeth? \_\_\_\_\_

Please rate your smile:      0      1      2      3      4      5      6      7      8      9      10

## MEDICAL HISTORY

Physicians Name: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Have you had any serious illness or operations? yes \_\_\_ no \_\_\_ If yes, describe: \_\_\_\_\_

### For female patients only:

Are you pregnant? yes \_\_\_ no \_\_\_      Nursing? yes \_\_\_ no \_\_\_      Taking birth control pills? yes \_\_\_ no \_\_\_

Do you require antibiotics prior to dental treatment? yes \_\_\_ no \_\_\_

### Please check if you have or have had any of the following:

- |                                                            |                                               |                                                |                                              |
|------------------------------------------------------------|-----------------------------------------------|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> AIDS                              | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Psychiatric care    |
| <input type="checkbox"/> Alzheimers, Dementia, memory loss | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Cough, persistent    | <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Artificial joints                 | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Rheumatic fever     |
| <input type="checkbox"/> Artificial heart valve            | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Latex allergy         | <input type="checkbox"/> Skin rash           |
| <input type="checkbox"/> Back problems                     | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Liver disease         | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Blood disease                     | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Thyroid problems    |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous problems      | <input type="checkbox"/> Tobacco habit       |
| <input type="checkbox"/> Chemical dependency               | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tonsillitis         |
| <input type="checkbox"/> Chemotherapy                      | <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Other (describe):                 | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Parkinson's disease   | <input type="checkbox"/> Ulcers              |
|                                                            |                                               |                                                | <input type="checkbox"/> Venereal disease    |

MEDICATIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

By signing, I acknowledge that I have read and answered the above questions to the best of my knowledge.

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

Date



# PATIENT INFORMATION

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

Legal name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Employer: \_\_\_\_\_ Who should we thank for referring you to us? \_\_\_\_\_

*If married:* Spouse's Name \_\_\_\_\_ Sp. DOB: \_\_\_\_\_ Sp. Employer \_\_\_\_\_

## PATIENT INFORMATION *(Complete if patient is a minor. If the patient is the guarantor, you may skip this section)*

Legal name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship to guarantor: \_\_\_\_\_ Social Security 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 insurance coverage, please complete the section below*

Policy holder name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_ Subscriber ID No: \_\_\_\_\_ Group No: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## AUTHORIZATION & RELEASE

By signing, I acknowledge that I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

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

\_\_\_\_\_  
Date



MID-VALLEY DENTAL ASSOCIATES

Taylor C. Bennion, DMD

## 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 \_\_\_\_\_



# 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

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### For Program Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) \_\_\_\_\_