

Full Name _____ Prefer _____
 Address _____
 P.O. Box _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Birth Date _____ Soc Sec _____ Drivers Lic _____
 E-mail _____

Sex: ___ Male ___ Female Marital Status: ___ Married ___ Single ___ Other
 Employment Status: ___ Full Time ___ Part Time ___ Retired ___ Other
 Student Status: ___ Full Time ___ Part Time ___ School
 Person to contact in case of emergency _____ Phone _____
 How did you hear about us? _____
 Responsible Party (if someone other than patient)
 Full Name _____ Phone _____
 Relationship to patient _____

Primary Insurance Information:

Name of Insured: _____ Insured Soc Sec: _____
 Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other Insured Birth Date: _____
 Employer: _____
 Insurance Company: _____ Group Number: _____
 Insurance Phone: _____ Policy Number: _____

I authorize my insurance company to pay River Mill Dental all insurance benefits otherwise payable to me of services rendered. I authorize the use of this signature on all insurance submissions.

I authorize River Mill Dental to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all services provided to me and/or my dependent(s), regardless of insurance payments.

I agree to pay all late and/or finance charges accrued on my account.

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits and eligibility. You agree to pay any portion of the charges not covered by insurance.

Signature _____ Date _____

Confirmation and Cancellation Policy

- Our office will contact you 2 days before your appointment. Do you prefer call/email/text? _____
- You, the patient, will give our office **48 hours'** notice if you need to move your appointment time or day.
- If we do not receive **48 hours'** notice, a fee will be charged for **less than 48-hour notice or failed appointment** to offset the preparation and resetting time for your treatment room.
- Remember, each appointment is set aside **exclusively for you or your family members**. Our goal is to be thoroughly prepared for you. Thank you for your understanding.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs, which may be incurred. If we must refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all the court costs. In case of suit, you agree the venue shall be in Clackamas County, OR.

WAIVER OF CONFIDENTIALITY: You understand if this account is submitted to an attorney or collection agency, if we must litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

FINANCE CHARGE: A finance charge will be imposed on each past due charge on your account, which has not been paid within sixty days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one- and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE OF EIGHTEEN PERCENT (18%). The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits to the account during that time. The minimum finance charge is \$0.50. If you have insurance, the finance charge will not be applied to outstanding insurance claims.

Signature _____ Date _____

Medical History

Name _____

When was the last time you were seen by a dentist? _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetic Other, please explain _____

Are you in good general health? _____

Have you been under the care of a Physician within the past two years? _____

Have you ever had a serious illness? If so, what? _____

Have you taken any medications for the following conditions?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Anticoagulants (blood thinners) | <input type="checkbox"/> Cortisone (steroids) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Asthma or Emphysema medication | <input type="checkbox"/> Hormones or birth control | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Insulin | |

List all medications _____

Have you ever had any hospitalizations or surgery? (list) _____

Women: Are you pregnant now? _____ Nursing? _____

Do you use tobacco? If so, how many packs a day? _____

Do you use alcohol? If so, how many drinks per week? _____

Do you use recreational drugs? _____

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Heart Valve/Stent | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chest Pain (angina) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Rheumatism | |

Financial/Payment Policy

PAYMENTS: Unless we approve other arrangements in writing, **payment is due at the time of service**. If you have insurance, and your insurance payment estimate is less than they actually pay, we will bill you for the remainder. The balance on your statement is due and payable on the date of issue and is past due if not received within two weeks.

PAYMENT OPTIONS:

- Cash/Check Discount-5% discount for payment in full by cash or check at the time of service if there is **not insurance**
- Pay full patient portion at the time of service. If the procedure requires 2 appointments, pay in full at the first appointment.
- For procedures requiring 2 appointments, pay half of treatment fee at the first appointment and the second half at the final appointment. If you have insurance, pay the half of the estimated portion at the first appointment, and the second half at the final appointment.
- RETURNED CHECKS: There is a fee (currently \$25) for any checks returned by the bank.

I acknowledge that I have read, and agree to the above financial terms

Signature _____ Date _____