Thank you for choosing Stillwater Dental and **welcome** to our practice! To help us provide the best care, please complete this form.

Patient Demographics *(Confidential)*

Name **Date of Birth** **Social**

Address **City** **State** **ZIP**

Email **Cell Phone** **Home Phone**

Minor **Single** **Married** **Divorced** **Widowed** **Separated**

If Student, **Name of School** **City** **State**

Employer **Job Title** **Part** **Full** **Phone**

Emergency Contact **Relation** **Phone**

Responsible Party *(Guarantor)*

Name of Responsible Party **Relationship to Patient**

Address **Home Phone** **Cell Phone**

Email **Driver's License #** **DOB**

Bank **Employer** **Phone**

Is this person currently a patient is our office? Yes No

For your convenience, we offer the following payment methods. Please check the option that works best for you:

Cash **Check** **Credit Card** **VISA** **MasterCard**

Insurance Information

Please bring your insurance card with you so that we can make a copy and verify benefits.

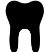
Patient Medical History **Physician** **Office Phone**

YES	NO	
		1. Are you currently under medical treatment?
		2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? *If yes, please explain*
		3. Are you taking any medication(s) including nonprescription medicine? *If yes, please list:*
		4. Have you ever taken Fen-Phen/Redux?
		5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?
		6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?
		7. Do you use tobacco?
		8. Do you use controlled substances?
		9. Are you wearing contacts?
		10. Do you have any food allergies? *If yes, please list:*

YES	NO	
		11. Are you allergic to any of the following?
		Local Anesthetics (e.g. Novocain)
		Penicillin or any other Antibiotics
		Sulfa Drugs
		Barbiturates
		Sedatives
		Iodine
		Aspirin
		Any Metals (e.g. nickel, mercury, etc.)
		Latex Rubber
		Other (please list)
		12. Do you have a cough or throat clearing not associated with a known illness (persisting more than 3 week)?
		13. Women Only:
		Are you pregnant or could you be?
		Are you nursing?
		Are you taking oral contraceptives?

Patient Medical History *(Continued)*

YES	NO		YES	NO		YES	NO	
		High Blood Pressure			Heart Disease			Chest Pains
		Heart Attack			Cardiac Pacemaker			Easily Winded
		Rheumatic			Heart Murmur			Stroke
		Swollen Ankles			Angina			Hay Fever/Allergies
		Fainting/Seizures			Frequently Tired			Tuberculosis
		Asthma			Anemia			Radiation Therapy
		Low Blood Pressure			Emphysema			Glaucoma
		Epilepsy/Convulsions			Cancer			Recent Weight Loss
		Leukemia			Arthritis			Liver Disease
		Diabetes			Joint Replacement or Implant			Heart Trouble
		Kidney Disease			Hepatitis/Jaundice			Respiratory
		AIDS or HIV Infection			Sexually Transmitted Disease			Mitral Valve Prolapse
		Thyroid Problem			Stomach Troubles/Ulcers			Other



Patient Dental History

Previous Dentist?

Last Exam?

YES	NO		YES	NO	
		1. Have/do you pre-medicate prior to dental treatment?			10. Do you clench or grind your teeth?
		2. Do your gums bleed when you floss?			11. Do you bite your lips or cheeks frequently?
		3. Are your teeth sensitive to hot or cold liquids/ foods?			12. Have you ever had any difficult extractions?
		4. Are your teeth sensitive to sweet or sour liquids/ foods?			13. Have you ever had any prolonged bleeding following extractions?
		5. Do you feel pain in any of your teeth?			14. Have you ever had braces?
		6. Do you have any sores or lumps in or near your mouth?			15. Do you wear dentures or partials If yes, date of placement
		7. Have you ever had any head, neck or jaw injuries?			16. Have you ever received oral hygiene instructions Regarding the care of your teeth and gums?
		8. Have you ever experience any of the following symptoms in your jaw? a. Clicking b. Pain (joint, ear, side of face) c. Difficulty opening or closing d. Difficulty chewing			17. Do you like your smile?
		9. Do you have frequent headaches?			18. Do you snore?
					19. Do you use a CPAP machine?

✓ Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Stillwater Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Stillwater Dental or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments

Signature: Date:

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Stillwater Dental! Mark E. Jensen, DMD and Tran Miller, DMD are happy to assist you in your dental needs. We are committed to providing you with the highest quality care.

We ask that you read and sign this form to acknowledge your understanding of our patient financial policies. Stillwater Dental, LLC, will do their best to verify your insurance benefits for you if you have coverage, however this is not a guarantee of payment. We strongly encourage you to confirm your benefits prior to your first appointment. The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care. We will bill your insurance for you. However, the patient is required to provide the most current and updated information regarding insurance.

Patients are responsible for payment of Copays, Coinsurance, Deductibles, and all other procedures or treatment not covered by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles, and non-covered treatment procedures are due at time billing statement arrives.

Cancellation Policy: Please contact Stillwater Dental, LLC if you are unable to keep your appointment. We reserve the right to charge $50, per hour booked, for failure to call and cancel your appointment at least 24 hours in advance.

(Please Initial in the box that you have read and agree to this policy)

I, the undersigned: (Please Pick One of the Boxes Below)

- I Do Have Health Insurance coverage and authorize direct payment from my insurance carrier to Stillwater Dental.
- I Do Not Have Insurance coverage and understand that I am responsible for all charges at the time of service.

You will be charged a fee of $35 if there is a returned check. In the event a check is returned, you will be asked to pay by cash or credit card for future visits. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.

Acknowledgment: I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to Stillwater Dental, including co-payments, deductibles, and amounts due for non-covered services that are not payable by my insurance.

PATIENT SIGNATURE: DATE:

PARENT/GUARDIAN must sign if patient is under the age of 18.

SIGNATURE: DATE:

* You may request a copy of this form

Notice of Privacy Practices Acknowledgement

Stillwater Dental, LLC

I, , have been given and have reviewed this office's Notice of Privacy Practices.

Patient's Signature

Date

Thank you for your time and please give us a call if you need assistance. (541)330-5952

For Office Use Only

We attempted to obtain a written acknowledgement of patient's knowledge of our Notice of Privacy Practices, but we were unable to do so due to the below reason:

Patient refused to sign

Other as described below

Date

Initials

Reason