Skyline Dental
www.skylinedentalbend.com
2137 NE 4th St. • Bend, OR 97701
info@skylinedentalbend.com
(541)389-4807

New Patient Form

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employer and Work Phone Number:

_____

_____

Occupation:

_____

_____

How do you prefer our office to contact you for appointment confirmations?
☐ Email ☐ Text ☐ Phone ☐ Other

Referred to our office by:

_____

_____

Emergency Contact

Name, relationship, phone number and address of Relative or Person NOT LIVING with you

_____

_____

_____

Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Responsible Party's Employer and Work Number:

_____

_____

Responsible Party's Occupation:

_____

_____

How would you prefer to pay for your portion of the provided services?

☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit ☐ Other

Primary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Group Name and Number:

_____

_____

Subscriber ID Number and Date of Birth:

_____

_____

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Group Name and Number:

_____

_____

Subsciber ID Number and Date of Birth:

_____

_____

☐ **By checking this box I acknowledge that all of the information submitted on this form to Skyline Dental is true and accurate to the best of my knowledge.**

Response Date: _____

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MEDICAL HISTORY FORM

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Physicians Name and Last Complete Physical:

_____

_____

Are you currently taking any medications? ○ Yes ○ No

If 'Yes', please list all medications you are taking and their purpose; including over the counter, herbal supplements and vitamins.

_____

_____

_____

Are you allergic to any of the following medications?

☐ Penicillin ☐ Latex ☐ Local Anesthetics ☐ Sulfa ☐ Other

☐ None

Please list any other medications that you are allergic to:

_____

_____

Please select which boxes apply to your Medical History:

☐ Need antibiotic coverage prior to dental work
☐ Undergone radiation
☐ Currently use tobacco products
☐ Subject to prolonged bleeding
☐ Subject to fainting
☐ (WOMEN) Currently pregnant
☐ None of the listed medical conditions apply
☐ Artificial joint replacement
☐ Undergone IV chemotherapy
☐ Have used tobacco products in the past
☐ Excessive thirst and/or urination
☐ Recently hospitalized or past major surgeries
☐ (WOMEN) Currently Nursing

If you selected any of the boxes above, please explain:

_____

_____

_____

Please list any major surgeries or hospitalizations in which you have had:

_____

_____

Please select the boxes below, if you are currently, or have ever been diagnosed or treated for:

- ☐ Heart Disease
- ☐ Congenital Heart Defects
- ☐ Abnormal Blood Pressure
- ☐ Cancer
- ☐ Shortness of Breath
- ☐ Diabetes
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Jaundice or Hepatitis
- ☐ Asthma or Hay Fever
- ☐ Chronic or Persistent Cough
- ☐ Glaucoma
- ☐ Autoimmune Disorders
- ☐ Drug or Substance abuse
- ☐ Neck or Back Problems
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis or Lung Disease
- ☐ Thyroid disease
- ☐ Ulcer/Colitis
- ☐ Epilepsy or Seizures
- ☐ Hemophilia
- ☐ Kidney Disease or Dialysis
- ☐ Sinus Problems
- ☐ Osteoporosis (or other bony disease)
- ☐ Long-Term Steroid Treatment
- ☐ AIDS/HIV
- ☐ Eating Disorders
- ☐ None of the listed medical conditions apply

If you selected any of the boxes above, please explain:

_____

_____

Do you have any other medical condition not listed?

_____

_____

Is there any condition or issue that you prefer to talk to the doctor in private about? ○ Yes ○ No

Signature _____ **Date** _____

Response Date: _____

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DENTAL HISTORY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Reason for your visit to our office?

_____

_____

When was your last dental visit?

_____

_____

Have you ever had a serious problem associated with previous dental treatment? ○ Yes ○ No

If 'yes', please explain:

_____

_____

_____

How often do you brush your teeth? _____

What dental aids do you use?

☐ Floss ☐ Water Pik ☐ Toothpick
☐ Electric/Sonicare Toothbrush ☐ Perio Aid ☐ Other

Are you familiar with the term 'Preventive Dentistry'? ○ Yes ○ No

When used properly, do you believe in the dental benefits of Fluoride? ○ Yes ○ No

Do you plan on maintaining your teeth for the rest of your life? ○ Yes ○ No

Please select any of the following which apply to you:

- ☐ Gums bleed during brushing or flossing
- ☐ Gums feel tender or swollen
- ☐ Pain with brushing or flossing
- ☐ Frequent sensitivity to cold, hot or sweets
- ☐ Usually break fillings or teeth
- ☐ Pain with biting or chewing
- ☐ Jaws frequently feel tired or sore
- ☐ Regularly clench or grind your teeth
- ☐ Bad odors or tastes in mouth
- ☐ Apprehensive or nervous about dental work
- ☐ Currently (or previously) use a mouthguard or splint
- ☐ Frequent cold sores, blisters or other oral/lip lesions
- ☐ Food frequently gets caught between teeth
- ☐ Previous (or current) Periodontal (gum) surgery
- ☐ Previous (or current) Orthodontics (braces)
- ☐ Previous (or current) biopsy of mouth, lips or face
- ☐ Currently unhappy with the appearance or color of your teeth or smile
- ☐ Either took fluoride as a child, or grew up in a fluoridated community
- ☐ Currently using a Tartar Control, Whitening or Baking Soda Toothpaste
- ☐ None of the listed dental conditions apply

☐ **By checking this box I acknowledge that all of the information submitted on this form to Skyline Dental is true and accurate to the best of my knowledge.**

Response Date: _____

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Thank you for choosing Skyline Dental for your dental needs. We always strive to provide you with the highest quality of care in a compassionate and friendly atmosphere. We are committed to support you in understanding your dental health, so that you will always be able to make the best choices for your dental care. We hope that you and your family will feel welcome in our dental family, and would like to acquaint you with our office policies.

CONSENT FOR TREATMENT:

Patient Name: _____* _____* ___ _____

Last First MI Preferred Name

Consent for Treatment

I hereby authorize this Dental Practice to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment: such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Minors or Children

Because the patient is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for all bills incurred on behalf of this child during their dental treatment.

○ Yes ○ No

FINANCIAL POLICY:

In the interest of providing the highest quality of care for our patients it is necessary to establish a financial policy to avoid any misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end. Payment is required for all dental services on the day they are rendered. To assist our patients, we offer the following methods for taking care of their account at our office:

- We offer a 5% discount when dental treatment is paid in full with cash or check on the day that treatment is rendered.

- We accept Visa, Mastercard, Discover and American Express. The discount does not apply.

-We offer financing through Care Credit which offers up to 12 months deferred interest financing as well as long term financing options with low interest rates. You must qualify to use any of the plans offered by care credit, and they have an easy application process. Please do not hesitate to ask us about this option.

- If you have dental insurance, we are happy to submit claims to your insurance company for you, as a courtesy. In order to do so you must provide us with your current insurance card and/or any additional necessary information. However please be advised that all estimated patient responsibility after insurance is due at the time of service. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account. We can not accept responsibility for collection of an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier, and we are unable to guarantee payment made by your insurance carrier. You are ultimately responsible for payment of your account.

FAILED OR CANCELLED APPOINTMENTS:

Appointment times are reserved especially for you. Please be on time so that the scheduled treatment can take place.

We kindly ask that you give us 24-hour notice if you are unable to keep an appointment. There will be a $50 fee for failed appointments. We are unable to continue to offer appointments to patients who fail multiple appointments without giving us proper notice. You may leave a message on our after-hours voicemail if you find out that you are unable to honor an appointment after our office has closed for the day.

ESTIMATES AND FEES:

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All Estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. Except for extreme emergencies, financial arrangements are to be made before treatment is rendered. There is a service charge on all unpaid accounts over 60 days.

DELINQUENT ACCOUNTS:

Delinquent accounts which have been turned over to a Credit Reporting Collection Agency will have their balances increased 50% to cover the expenses associated with the Collection Agency. In addition to these collection agency expenses; delinquent accounts are also liable for Attorney fees and court costs associated with the collection of the debt.

NOTICE OF PRIVACY PRACTICES (HIPAA):

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

Our goal is to ensure that you have an excellent experience at Skyline Dental. (Signature will be obtained upon checking in for your appointment.)

Signature _____ **Date** _____

Response Date: _____