

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

IF CHILD:  
PARENT'S NAME \_\_\_\_\_  
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED \_\_\_\_\_  
 Single  Married  Separated  Divorced  Widowed  Minor  Domestic Partner

RESIDENCE - STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE: RES. \_\_\_\_\_ BUS. \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

EMAIL \_\_\_\_\_

PATIENT/PARENT EMPLOYED BY \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

BUSINESS PHONE NUMBER \_\_\_\_\_

DRIVERS LICENSE NO. \_\_\_\_\_

PURPOSE OF CALL \_\_\_\_\_

\_\_\_\_\_

OTHER FAMILY MEMBERS IN THIS PRACTICE \_\_\_\_\_

\_\_\_\_\_

WHOM MAY WE THANK FOR THIS REFERRAL \_\_\_\_\_

\_\_\_\_\_

PATIENT/PARENT SOCIAL SECURITY NO. \_\_\_\_\_

SPOUSE/PARENT SOCIAL SECURITY NO. \_\_\_\_\_

SOMEONE (NOT LIVING WITH YOU) TO NOTIFY IN CASE OF EMERGENCY \_\_\_\_\_

\_\_\_\_\_

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid, in whole or in part by my dental care payor. I understand that I am responsible for my child's account.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ REVIEWED & UPDATED \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

### DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

TELEPHONE \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

### DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

TELEPHONE \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

# REGISTRATION

PATIENT'S NAME \_\_\_\_\_  
 Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

**CURRENT MEDICATIONS**

1. Previous Dentist Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_
2. Physician's Name \_\_\_\_\_  
 Address \_\_\_\_\_
3. Are you under a physician's care? .....YES NO  
 Since when \_\_\_\_\_ Why \_\_\_\_\_
4. When was your last complete physical exam? \_\_\_\_\_
5. Are you taking any medication or substances? .....YES NO  
 (If yes, please list medications to the right)
6. Do you routinely take health related substances? .....YES NO
7. Are you allergic to any medications or substances? (If yes, please list) .....YES NO
8. Do you have any other allergies? .....YES NO
9. Do you have any problems with penicillin, antibiotics, anesthetics  
 or other medications? (**please list**) .....YES NO
10. Are you sensitive to any metals or latex? .....Metal ...Latex NO
11. Are you pregnant or suspect you may be? .....YES NO
12. Do you use any birth control medications? .....YES NO
13. Have you ever been treated for or been told you might have heart disease? .....YES NO
14. Do you have a pacemaker or an artificial heart valve implant? .....YES NO
15. Have you ever had rheumatic fever? .....YES NO
16. Are you aware of any heart murmurs? .....YES NO
17. Do you have high or low blood pressure? .....High...Low...Normal
18. Have you ever had a serious illness or major surgery? .....YES NO  
 If so, explain \_\_\_\_\_
19. Have you ever had radiation treatment, chemo treatment for tumor,  
 growth or other condition? .....YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? .....YES NO
21. Do you have any artificial joints/prosthesis? .....YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? .....YES NO
23. Have you ever bled excessively after being cut or injured? .....YES NO
24. Do you have any stomach problems? .....YES NO
25. Do you have any kidney problems? .....YES NO
26. Do you have any liver problems? .....YES NO
27. Are you diabetic? .....YES NO
28. Do you have asthma? .....YES NO
29. Do you have epilepsy or seizure disorders? .....YES NO
30. Do you or have you had venereal disease? .....YES NO
31. Have you tested HIV positive? .....YES NO
32. Do you have AIDS? .....YES NO
33. Have you had or do you test positive for hepatitis? .....YES NO
34. Do you or have you had T.B.? .....YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? .....YES NO
36. Do you consume alcoholic beverages? .....YES NO
37. Do you habitually use controlled substances? .....YES NO
38. Have you had psychiatric treatment? .....YES NO
39. Is there anything else we should know about your health that we have not covered in this form?  
 \_\_\_\_\_
40. Would you like to speak to the Doctor privately about any problem? .....YES NO

**PATIENT COMMENTS:**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ REVIEWED & UPDATED: \_\_\_\_\_

**ANEST.**

**MED. ALERT**

# MEDICAL HISTORY

# Ernest Thompson, D.M.D., P.C.

3895 SW 185<sup>TH</sup> Avenue Suite 130

Aloha, Oregon 97007

Office: (503) 649-5900

Fax: (503) 649-9047

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. We normally require payment in full for your estimated portion due, one week in advance, unless other arrangements are made. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the following payment options:*

## **PAYMENT OPTIONS**

*(Please check one)*

**Full Payment of day's services with a 5% discount** *(if paid by cash or check).*

**1/2 down payment, the balance in 3 monthly payments** *(\$600 limit).*

**By insurance and my share at each appointment.** *(Patients who are part of an Insurance Preferred Provider Organization (PPO) receive a discounted fee up front for our services. There are no cash discounts available beyond this).*

**I would be interested in financing services.**

*We gladly accept Visa or MasterCard*

**\*IF FOR ANY REASON THE ESTIMATED AMOUNT IS NOT PAID BY YOUR INSURANCE COMPANY, IT BECOMES YOUR RESPONSIBILITY.**

Date: \_\_\_\_\_ Responsible Party Signature: \_\_\_\_\_ Auth: \_\_\_\_\_



Patient: \_\_\_\_\_

The Office of Ernie Thompson, D.M.D., P.C. 3895 SW 185<sup>th</sup> Ave. Aloha, OR 97007

### Financial Policy

**Usual & Customary Fees:** Our fees are comparable to the usual & customary fees charged by like general dentists in this area. These charges are based on the cost of materials, as well as the time and skill involved. These fees are not necessarily the same as what your insurance considers “usual & customary.” We normally require payment in full for your estimated portion due one week in advance, unless other arrangements are made.

**Insurance:** We ask you assign your insurance benefit to us. Professional care is provided to you, our patient, and not your insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. *We will help in every way we can to file your claim.* We bill your insurance one time as a courtesy to you. Any follow-up required will be the patient’s responsibility. The patient is ultimately responsible for the bill and/or any balance left owing after insurance has paid including finance charges. If insurance has not paid within 60 days, the bill becomes the patient’s responsibility. *We require deposit equal to the estimated amount not payable by insurance as treatment is provided.*

**Payment policy for patients without insurance:** In an effort to keep dental costs down while maintaining a high level of professional care we have established the following payment plans for the use of our patients. A 5% discount, 10% for senior citizens, with cash or check payment in full at the time of treatment. Visa and Mastercard accepted. Extended payments are available upon credit approval from our outside financial institution. Accounts outstanding more than 60 days from treatment dates could be charged interest at 1 1/2% per month or 18% per year.

**Attorney or Accident Referrals:** Patients referred by attorneys and/or involved in accidents, with pending litigation, regarding the accident or injury are responsible for all services rendered regardless of pending legal or insurance action. We require the patient to pay in full at time of service for all third party insurance. We will provide all paperwork necessary for the patient to bill the insurance. If additional notes are required, a charge may be assessed for processing.

**Other:** A parent must be present with treatment of a minor (under age 18). A \$25 service fee will be assessed for all returned checks. A \$25 charge may be assessed for all broken appointments unless 24 hours notice is given.

**Risks of Dental Procedures:** Possible (but not limited to) complications include the following conditions: pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps, spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medications and drugs may cause drowsiness, and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus, it is advisable not to operate a vehicle or hazardous device or work for twenty-four hours or until recovered from their effects.

**Consent to Treatment:** I understand that upon request I may receive a copy of this form. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me, and members of my family shown by statements, promptly upon presentment thereof, unless protested in writing within thirty days of billing date. In the event, legal action should become necessary to collect an unpaid balance due for services rendered to me, or my family, I agree to pay reasonable attorney’s fees or other such costs. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Ernie Thompson, D.M.D., P.C.*

*3895 S.W. 185th Ave., Suite 130 • Aloha, Oregon 97007 • (503) 649-5900*

Ernie Thompson DMD, P.C.  
3895 SW 185<sup>th</sup> Avenue, Suite 130  
Aloha, OR 97007-1500

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*\*You May Refuse to Sign This Acknowledgement\**

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practice.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### **For Office 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 because:

\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_ Communications barriers prohibited obtaining the acknowledgement

\_\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

# PATIENT COPY

Ernest R. Thompson, DMD, P.C.

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## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We may use or disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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#### **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.10 for each page \$15. per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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#### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ernest R. Thompson, DMD, P.C.

Telephone: 503-649-5900

Fax: 503-649-9047

E-mail: \_\_\_\_\_

Address: 3895 SW 185th Avenue, Suite 130 Aloha, OR 97007-1500

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