# Holly Chamberlain D.D.S.

858 Commercial St. NE, Salem, OR 97301

(503) 363-8625 Fax: (503) 363-0027


**WELCOME!** ***Thank You For Selecting Our Dental Team!*** **Date:** _____

Patient Name: _____ Nickname: _____
*Last* *First* *MI*

Birth Date: _____ Age: _____ Gender: _____ SS: _____ Driver's License: _____

Home Address: _____
*Street* *City* *State* *Zip*

Main Phone: _____ Work Phone: _____

Employer: _____ Address: _____

Other family seen by us/Who Referred You? _____

**Spouse / Parent / Guardian Information**

Name: _____ Birth Date: _____ SS: _____

Employer: _____ Phone: _____ Driver's License: _____

**Emergency Contact Not Living With You**

Name: _____ Relation: _____ Home: _____

Home Address: _____
*Street* *City* *State* *Zip*

## Insurance Information

***Primary Insurance:*** _____ Phone: _____ Group: _____

Insurance Co. Address: _____
*PO Box/ Street* *City* *State* *Zip*

Insured's Name: _____ Insured SS: _____ Birth Date: _____

Insured's Employer: _____ Employer Address: _____

***Secondary Insurance:*** _____ Phone: _____ Group: _____

Insurance Co. Address: _____
*PO Box/ Street* *City* *State* *Zip*

Insured's Name: _____ Insured SS: _____ Birth Date: _____

Insured's Employer: _____ Employer Address: _____

**Appointments:** Our office understands how valuable your time is. We strive to have our patients seen on time. We accommodate your schedule as much as possible when making appointments. Valuable clinical time is lost when appointments are missed or cancelled with short notice ***(less than 24 hours)***. You will be charged $50.00 per appointment for no show or short notice cancellations.

**If You Have Dental Insurance:** Dental insurance policies are very different. Most require an annual deductible. We will give you an approximate dollar amount of your portion owing after insurance. Your portion of uncovered expenses are due at time of your appointment. We cannot guarantee insurance payment. You will be billed for total treatment charges for insurance non-payment which is 90 days past due.

**If You Do Not Have Dental Insurance:** Payment is required at the time dental services are performed. You are financially responsible for the services you receive.

***I Have Read and Understand The Above Policies***

***Signature:*** _____ ***Date:*** _____

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*Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.*

Name: _____ Date: _____

| | | |
|---|---|---|
| Do you have a primary physician? | ☐Yes ☐ No | If yes, please explain: |
| Are you currently being treated by a physician? | ☐Yes ☐ No | If yes, please explain: |
| Have you ever been hospitalized or had a major operation? | ☐Yes ☐ No | If yes, please explain: |
| Have you ever had a serious head or neck injury? | ☐Yes ☐ No | If yes, please explain: |
| Are you taking any medications, pills, or drugs? | ☐Yes ☐ No | If yes, please explain: |
| Do you take, or have you taken, Phen-Fen or Redux? | ☐Yes ☐ No | |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ☐Yes ☐ No | |
| Are you on a special diet? | ☐Yes ☐ No | |
| Do you use tobacco? | ☐Yes ☐ No | |
| Do you use controlled substances? | ☐Yes ☐ No | |
| Are you Pregnant/Trying to get pregnant? | ☐Yes ☐ No | (Women) |
| Nursing? | ☐Yes ☐ No | (Women) |
| Taking oral contraceptives? | ☐Yes ☐ No | (Women) |

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs ☐Other

If other, please explain: _____

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

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Cortisone Medicine | ☐ Hemophilia | ☐ Radiation Treatments |
| ☐ Alzheimer's Disease | ☐ Diabetes | ☐ Hepatitis A | ☐ Recent Weight Loss |
| ☐ Anaphylaxis | ☐ Drug Addiction | ☐ Hepatitis B or C | ☐ Renal Dialysis |
| ☐ Anemia | ☐ Easily Winded | ☐ Herpes | ☐ Rheumatic Fever |
| ☐ Angina | ☐ Emphysema | ☐ High Blood Pressure | ☐ Rheumatism |
| ☐ Arthritis/Gout | ☐ Epilepsy or Seizures | ☐ High Cholesterol | ☐ Scarlet Fever |
| ☐ Artificial Heart Valve | ☐ Excessive Bleeding | ☐ Hives or Rash | ☐ Shingles |
| ☐ Artificial Joint | ☐ Excessive Thirst | ☐ Hypoglycemia | ☐ Sickle Cell Disease |
| ☐ Asthma | ☐ Fainting Spells/Dizziness | ☐ Irregular Heartbeat | ☐ Sinus Trouble |
| ☐ Blood Disease | ☐ Frequent Cough | ☐ Kidney Problems | ☐ Spina Bifida |
| ☐ Blood Transfusion | ☐ Frequent Diarrhea | ☐ Leukemia | ☐ Stomach/Intestinal Disease |
| ☐ Breathing Problem | ☐ Frequent Headaches | ☐ Liver Disease | ☐ Stroke |
| ☐ Bruise Easily | ☐ Genital Herpes | ☐ Low Blood Pressure | ☐ Swelling of Limbs |
| ☐ Cancer | ☐ Glaucoma | ☐ Lung Disease | ☐ Thyroid Disease |
| ☐ Chemotherapy | ☐ Hay Fever | ☐ Mitral Valve Prolapse | ☐ Tonsillitis |
| ☐ Chest Pains | ☐ Heart Attack/Failure | ☐ Osteoporosis | ☐ Tuberculosis |
| ☐ Cold Sores/Fever Blisters | ☐ Heart Murmur | ☐ Pain in Jaw Joints | ☐ Tumors or Growths |
| ☐ Congenital Heart Disorder | ☐ Heart Pacemaker | ☐ Parathyroid Disease | ☐ Ulcers |
| ☐ Convulsions | ☐ Heart Trouble/Disease | ☐ Psychiatric Care | ☐ Venereal Disease |
| | | | ☐ Yellow Jaundice |

Have you ever had any serious illness not listed above? ☐Yes ☐ No

Comments: _____

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.*

Signature or Patient or Parent of Minor _____ Date _____

Doctor's Signature _____ Date _____

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## Notice of Privacy Practices (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I can receive a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Parent or Guardian Name/ Relationship: _____

Signature: _____ Date: _____

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**Office Use Only**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |