



Lake Oswego Smiles

Please use your keyboard and mouse to complete this form. You can then print it out and mail, fax or bring it with you to your next appointment. Our mailing address is: Dr. Colin Smith, 16699 S.W. Boones Ferry Road Suite 200, Lake Oswego, OR 97035. Our fax number is 503-635-3654.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date _____

Soc. Sec. # _____

Birthdate _____

Patient's Name _____

How do you wish to be addressed? _____

Address _____
(Street) (City) (State) (zip)

Home Phone _____ Cell Phone _____ Email _____

(Check Appropriate Box) Minor Single Married Divorced Widowed Separated

Whom may we thank for referring you to this office? _____

Address _____
(Street) (City) (State) (zip)

Patient's Employer: _____ Work Phone _____

Address _____
(Street) (City) (State) (zip)

Spouse or Parent's Name _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

Spouse or Parent's Employer _____ Work Phone _____

Person Responsible for this Account _____

Address _____ Phone _____

Relationship to Patient _____ Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____

Person to contact in case of emergency or to change appointment of patient cannot be reached:

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION:

Name of Insured _____ Relationship to Patient _____

Primary Insurance Carrier Name _____

ID # _____ Group # _____

Secondary Insurance Carrier Name _____

ID # _____ Group # _____

Do you have a Co-Pay with your insurance plan for office visits? _____

If so, what is the amount? _____ Co-Pay's are to be paid at the time of service.

For your convenience, we offer the following methods of payment. Please check the option you prefer.

- Cash Personal Check Credit Card VISA MasterCard I wish to discuss other options.

AUTHORIZATION AND RELEASE:

I/We authorize the dentists and staff of Oswego Smiles in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. I/We acknowledge that no guarantees have been made as to the results of my treatments, tests or procedures, and I/We authorize copies of the medical records to be released to other physicians, dentists or health care facilities as deemed necessary.

ASSIGNMENT OF BENEFITS:

I/We assign all benefits to Oswego Smiles, and authorize direct payment to Oswego Smiles of all insurance benefits to which I/We or the patient may be entitled. This assignment specifically includes, but is not limited to, insurance proceeds and benefits as well as proceeds and benefits accruing under any settlement, structured or otherwise, or award in judgment for injuries and damages caused by a third party.

FINANCIAL RESPONSIBILITY.

I/We agree to pay for any and all charges not paid pursuant to this assignment, and a photocopy of this assignment shall be as valid as an original. I/We understand that I/We am/are financially responsible to Oswego Smiles as the patient, parent, guardian, conservator, insured or guarantor for all charges not covered by the above assignment, which charges may include any dental insurance deductibles or co-insurance. [I/We understand to sign as a guarantor means that if the patient does not pay Oswego Smiles for all charges due, I/We, as the guarantor, will be responsible for such payment. I/We authorize Oswego Smiles and any dentist, staff member, or office administrator for Oswego Smiles to release any medical information about the patient necessary to determine any benefits which maybe payable for this treatment. I/We understand that I/We am/are responsible for all fees and costs regardless of the insurance coverage. I/We agree to pay a late payment fee at the rate of 1.5 percent per month on any amounts due from and after the thirty-first day following the invoice date until paid in full if there is no applicable insurance coverage. If a claim for insurance is pending, no late payment fee shall accrue until such time as the insurance company denies all or part of a claim, in which case I/We agree to pay late payment fee at the rate of 1.5 percent per month on any unpaid amounts from and after the thirty-first day following the date Oswego Smiles or I/We receives notice of the same from the applicable insurance company, whichever is earlier. I/We also agree that if any dispute arises between Oswego Smiles, its representatives or employees and me, the laws of the State of Oregon. shall govern, and all such disputes must only be litigated in the appropriate court in Clackamas County, Oregon, and I/We consent to personal jurisdiction and venue being proper in the appropriate court located in Clackamas County, Oregon.

The undersigned certifies that he or she is the patient or is duly authorized by or on behalf of the patient to execute the above and accept such terms and conditions.

Date: _____

Patient's signature

Date: _____

Parent, Guardian, Conservator, Insured,
Power of Attorney, Guarantor

PATIENT HISTORY

Physician _____ Office Phone _____ Last Date of Exam _____

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| <p>1. Are you under medical treatment now? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please explain _____</p> <p>3. Are you taking any medication (s) including non-prescription medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken a biophosphate medication? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Do you use tobacco <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Do you use controlled substances? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Have you ever been treated for substance abuse? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. Are you wearing contact lenses? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. Do you have or have you had any of the following? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>10. Are you allergic to or have you had any reactions to the following? YES NO</p> <p>Local Anesthetics (e.g. Novocaine) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Penicillin or any other antibiotics <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Sulfa Drugs <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Barbituates <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Sedatives <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Iodine <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Aspirin <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Any metals (e.g., nickel, mercury, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Latex Rubber <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other (please list) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. Women Only:</p> <p>a. Are you pregnant or think you may be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b. Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c. Are you taking oral contraceptives? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
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| <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy/Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis/Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles/Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Chest pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever/Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Last Date of Exam and X-rays _____
 Previous Dentist's Location _____ Date of Last Cleaning _____

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| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had any head, neck or jaw injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Have you ever experienced any of the following problems in your jaw? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Clicking <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Pain (Joint, ear, side of face) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Difficulty in opening or closing <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Difficulty in chewing <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you ever "whitened" your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>8. Do you have frequent headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. Have you ever had difficult extractions in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>16. Do you like your smile? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>17. How would you rate your fear of dental work?
 <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High</p> <p>18. Have you been treated for gum disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
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If you could change one thing about your teeth or smile, what would it be?

 (Signature of Patient or Parent if Minor)

 Date:

Doctor's Notes

Signature: _____

Date: _____