

North Bend Family Dentistry

~227 W 2nd Street, North Bend~

888~2330

PATIENT INFORMATION

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Sex: M F Age _____ Birth date _____
 Single Married Widowed Divorced
Patient SS# _____
Occupation _____
Employer _____
Employer Address _____
Spouse's Name _____
Birth date _____ SS# _____
Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
If yes: Subscriber's Name _____
Relationship to Patient _____
Birth date _____ SS# _____
Insurance Co. _____ Group # _____
Employer _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Galloway all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell _____
Spouse's Work _____ E-mail address _____ Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone _____ Work or Cell Phone _____

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____
Place a mark on "Yes" or "No" to indicate if you have had any of the following:
Bad breath Yes No
Bleeding gums Yes No
Blisters on lips Yes No
Burning sensation on tongue Yes No
Chew on one side of mouth Yes No
Clicking or popping jaw Yes No
Dry mouth Yes No
Fingernail biting Yes No
Food collection between the teeth Yes No
Foreign objects Yes No
Grinding teeth Yes No
Gums swollen or tender Yes No
Jaw pain or tiredness Yes No
Lip or cheek biting Yes No
Loose teeth or broken fillings Yes No
Mouth breathing Yes No
Mouth pain, brushing Yes No
Orthodontic treatment Yes No
Pain around ear Yes No
Periodontal treatment Yes No
Sensitivity to cold Yes No
Sensitivity to heat Yes No
Sensitivity to sweets Yes No
Sensitivity when biting tobacco Yes No
Smoking or chewing tobacco Yes No
Sores or growths in your mouth Yes No
How often do you floss? _____
How often do you brush? _____

HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, w/ extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		WOMEN:			
		Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Due date _____			
		Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____
 Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

Agreement of Financial and Personal Responsibilities

In accordance with the Federal Truth-in-Lending Act, which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in our office. The responsible party agrees:

- To pay the doctor at the time treatment is received, or by previous arrangements.
- That if payments are extended beyond 30 days from the date of first billing, to pay interest at 1% per month on the unpaid balance (12% annual rate) with a minimum charge of \$1.00 per month. Interest not paid on time is added to and becomes part of the principal.
- To a \$25.00 charge on all returned checks.
- In the event my insurance company does not cover the entire balance of this account within 30 days from the date of service, I agree to pay the balance in full within 60 days from the date of service, or by previous arrangements.
- Personal credit may be checked.
- All costs incurred in collecting overdue balances will be charged to the patient or responsible party.
- A fee may be charged if a patient does not show up for an appointment without sufficient notice.

 Patient, Parent or Guardian

 Date