Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

How Did You Hear About Us?

☐ **Phone Book**	☐ **Street Sign**	☐ **Statesman Journal**
☐ **Insurance:**	☐ **Postcard**	☐ **Facebook**
☐ **Internet Site:**	☐ **Is there someone we can thank for referring you?**	☐ **Other:**

Responsible Party **Who is responsible for the account?**	
Name:	
Relationship to patient:	
Birthdate:	
Driver's License#:	
SS# or Subscriber Identification # (SIN):	
Address:	
City:	
State:	
Zip:	
Employer:	
Occupation:	**Best way to verify appt.:**
Work Phone:	☐ Work
Home Phone:	☐ Home
Cell Phone:	☐ Cell
E-mail:	☐ E-mail

Financial Arrangements	**Late Charges**
For your convenience, we offer the following methods of payment. Please check the option which you prefer: ☐ **Cash** ☐ **Debit Card** ☐ **Credit Card** ☐ **Care Credit** *Personal checks are not accepted. Payment is expected at the time of service.	If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. **Signature**_____ **Date**_____

Turn Page Over →

Primary Dental Insurance Information	Secondary Dental Insurance Information
Name of Insured:	Name of Insured:
Relationship to Patient:	Relationship to Patient:
Insured's Birthdate:	Insured's Birthdate:
SS#/SIN:	SS#/SIN:
Employer:	Employer:
Insurance Company:	Insurance Company:
Group #:	Group #:
Employee/Cert.#:	Employee/Cert.#:
Ins. Co. Address:	Ins. Co. Address:
Ins. Co. Phone:	Ins. Co. Phone:

Dental Insurance Agreement

We are happy to help you file your insurance claims to receive the dental benefits which your employer and you are paying premiums. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. Meaning your insurance plan will pay only what it allows for each service, regardless of what the actual fee is. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. Your Employee Benefits Director can usually help you become familiar with your plan and any restrictions that may apply. Our office is happy to assist you in maximizing your benefits.

We agree to:
Complete your insurance claim forms and submit them to your carrier for you after treatment in our office.
Use current American Dental Association coding for correct reporting of procedures.
Accept direct payment from your carrier and keep track of balances.
If necessary, re-file your insurance a second time.
Your responsibilities as a patient:
To pay fees not covered by your plan at the time of treatment.
To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
To pay any account balance not paid by insurance.

We thank you for choosing our office and will do all we can to help you maximize your benefits for the year. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help. We will keep one copy in your chart and will give you a copy for your records upon request.

I hereby authorize payment directly to the dental providers from my dental insurance company. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to this office to provide information to my insurance company regarding my dental treatment. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to other health practitioners.

_____ _____

Patient or Insured Date

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle* | Home Phone: *Include area code* | Business/Cell Phone: *Include area code*

Address: *Mailing address* | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of Birth: | Gender:

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: *Include area code* | Cell Phone: *Include area code*

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code*

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? Yes ☐ No ☐ DK ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐ DK ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? Yes ☐ No ☐ DK ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ☐ No ☐ DK ☐

Date Treatment began: _____

Do you use controlled substances (drugs)? Yes ☐ No ☐ DK ☐

Do you use tobacco (smoking, snuff, chew, bidis)? Yes ☐ No ☐ DK ☐

If so, how interested are you in stopping?
VERY ☐ / SOMEWHAT ☐ / NOT INTERESTED ☐

Do you drink alcoholic beverages? Yes ☐ No ☐ DK ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? Yes ☐ No ☐ DK ☐

Number of weeks: _____

Taking birth control pills or hormonal replacement? Yes ☐ No ☐ DK ☐

Nursing? Yes ☐ No ☐ DK ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐ DK ☐

Name of physician or dentist making recommendation: Phone: *Include area code*

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes ☐ No ☐ DK ☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, physicians and specialists, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below.** You may opt out by checking the "Do not Release Information" box below.

Name of authorized person: _____ Relationship: _____

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other

Name of authorized person: _____ Relationship: _____

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other

Name of authorized person: _____ Relationship: _____

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other

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☐ DO NOT release information to anyone.

With my signature below, I acknowledge and understand that this information will be kept in my dental record and the above listed will remain in effect until revoked by me in writing. **It is my responsibility to notify my dental office should I wish to change one or more contacts listed above.**

Patient's Name: _____ Date of Birth: _____

_____ Date: _____

Signature of patient or patient's authorized representative

Thank You!

Cochell Family Dentistry
PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name:_____ Date of Birth:_____

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed:_____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

_____
_____
_____

Signed:_____

File this form in the patient's chart

Dental Record and Radiograph Release Form

If you would like x-rays transferred from another office, please fill out the bottom of this form and mail or fax it to **your previous dentist.** This will authorize them to duplicate your records. At your first visit with us, **x-rays will be taken** if we have not received them from your previous dentist.

Prior office name: _____

Phone number: _____ Fax number: _____

Email address: _____

Please send any current radiographs (BWX, FMX and/or PANO) perio charting and any other pertinent dental information to:

Cochell Family Dentistry, P.C.
2225 Mission Street SE, Suite #100
Salem, OR 97302
Phone: 503-585-8688
Fax: 503-763-8719
Email: frontdesk@cochellfd.com

Patients
Name:_____Birthdate:_____

Address:_____

City:_____ State:_____Zip:_____

_____ _____
Relationship to patient Today's Date

_____
Signature (parent if minor)

Note: My appointment at Cochell Family Dentistry, P.C. is on:_____
Please be sure the records arrive before the scheduled appointment above.

Thank you!