PARKROSE DENTAL

Thomas T. Tieu, DMD
3620 NE 122ND AVE • PORTLAND OR • 503.254.5575
parkrosedental.com

HEALTH HISTORY

Patient Name:_____

Date: _____

Reason for seeking treatment: _____

Medical Doctor's Name:_____

Medical Doctor's Address:_____

Medical Doctor's Phone:_____

Do you have or have you had any of the following?
(Please check any that apply)

- ☐ AIDS/HIV
- ☐ Anemia, sickle cell anemia, or other bleeding disorder
- ☐ Angina (chest pain)
- ☐ Artificial joint prosthesis
- ☐ Asthma
- ☐ Bypass surgery
- ☐ Cancer - If so, what kind?_____
- ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Drug or alcohol abuse
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Glaucoma
- ☐ Heart abnormalities present since birth
- ☐ Heart attack or stroke
- ☐ Heart murmur
- ☐ Hepatitis or liver disease
- ☐ High blood pressure
- ☐ Kidney disease - If so, do you receive dialysis?_____
- ☐ Lung disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Stomach ulcers
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Venereal disease

Check square for YES.

- ☐ Are you in good health?
- ☐ Are you currently under medical care?
  If so, what's the condition being treated?_____
  Date of last physical exam_____
- ☐ Has there been any change in your health within the past year?
- ☐ Have you ever had a serious illness or operation?
- ☐ Have you ever had abnormal bleeding after an accident, surgery, or having a tooth pulled?
- ☐ Have you ever required a blood transfusion?
- ☐ Have you ever had surgery or x-ray (radiation) treatment for a tumor, growth, or other condition?
- ☐ Any disease, condition, or problem not listed?
  Please explain _____

Are you taking any of the following? (Please check any that apply)

- ☐ Alcohol
- ☐ Antibiotics
- ☐ Aspirin or NSAID's (Motrin, Advil, etc.)
- ☐ Birth control "pill"
- ☐ Blood thinners (Coumadin, Warfarin, Aspirin)
- ☐ Digitalis or drugs for heart disease
- ☐ Dilantin or other anti-seizure medicine
- ☐ Insulin or other drug(s) for diabetes
- ☐ Medicine for high blood pressure
- ☐ Narcotics (pain pills)
- ☐ Nitroglycerin
- ☐ Recreational drugs
- ☐ Steroids (cortisone, prednisone)
- ☐ Other_____

Are you allergic or have you ever reacted adversely to any of the following? (Please check any that apply)

- ☐ Local anesthetics (Novocaine, etc.)
- ☐ Penicillin or other antibiotics
  If other antibiotics, please specify_____
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Other_____

Check square for YES.

- ☐ Have you had any serious trouble associated with any previous dental treatment?
  If so, please explain_____
  _____
  Date of last dental exam_____
- ☐ Have you ever been treated for any gum disease? (gingivitis, periodontitis, trenchmouth, pyorrhea?)
- ☐ Do your gums bleed when you brush your teeth?
- ☐ Do you grind or clench your teeth?
- ☐ Have you had any injuries to your mouth or jaws?
- ☐ Do you have any sores or swelling of your mouth or jaws?

Women:

- ☐ Are you or could you be pregnant?

How many months pregnant?_____

_____ _____
Patient's Signature Date

_____ _____
Dentist' Signature Date

PARKROSE DENTAL

Thomas T. Tieu, DMD
3620 NE 122ND AVE • PORTLAND OR • 503.254.5575
parkrosedental.com

PATIENT INFORMATION

Last Name _____First Name_____ MI_____ circle one: MR. MRS. MS.

Birthdate _____ SS#_____Driver's License #_____ State _____

Mailing address _____ City _____State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____ Email _____

Employer _____ Occupation _____

How did you learn of our office? ☐ signage ☐ insurance co. ☐ zocdoc.com ☐ google.com ☐ parkrosedental.com ☐ facebook.com

☐ radio ☐ TV ☐ flyer ☐ online review site: _____ ☐ referred by:_____

Oter immediate family member(s) that are existing patients: _____

_____

May we contact you regarding upcoming appointments, reminders, or office specials via ☐ Email and/or ☐ Text Message

---

INSURANCE INFORMATION: ☐ Not covered by dental insurance/paying independently

Dental Insurance Co_____ Insurance Phone Number_____

Subscriber Name _____ Subscriber Date of Birth_____

Subscriber ID or Social Security # _____ Group Number_____

Subscriber Employer _____ Select plan type: ☐ Individual Plan ☐ Family Plan

Names of other members covered under this plan: _____

_____

RESPONSIBLE PARTY INFORMATION: ☐ Self ☐ Other

Name _____ Relationship To Patient _____

Cell Phone _____ Work Phone _____ Home Phone _____

By signing here, I accept responsibility for payment of charges incurred for the above patient.

Signature _____

EMERGENCY CONTACT Name: _____Relationship to patient_____

Cell Phone _____ Work Phone _____ Home Phone _____

Patient's Signature: _____ Date: _____

Parent/Guardian *(if patient is a minor):* _____

PARKROSE DENTAL

Thomas T. Tieu, DMD
3620 NE 122ND AVE • PORTLAND OR • 503.254.5575
parkrosedental.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ E-mail:_____

Patient Number:_____ Social Security Number:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Arik Herman
Telephone: 503-254-5575 Fax: 503-254-2162
E-mail: contact@parkrosedental.com
Address: 3620 NE 122nd Ave. Portland, OR 97230

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

PARKROSE DENTAL

Thomas T. Tieu, DMD
3620 NE 122ND AVE • PORTLAND OR • 503.254.5575
parkrosedental.com

PATIENT NAME:_____
Last First MI.

1. CONSENT FOR DENTAL SERVICES

I request and authorize my dentist and other dentists who may attend me, their associates and assistants, and Parkrose Dental (hereafter referred to as "Clinic"), its house staff and employees, to provide and perform such dental care, tests, procedures, drugs and other services and supplies as are considered advisable by my dentist for my health and well-being. This may include pathology, radiology, emergency services and other special services and tests ordered by my dentist. I acknowledge that no representations, warranties, or guarantees as to results or cures have been made to or relied upon by me.

2. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by the Clinic and all attending dentists, I hereby irrevocably transfer to the said Clinic all insurance benefits now due and payable to me or to become due and payable to me under my current insurance policy or policies, or any replacement policies thereof.

I hereby transfer payment of benefits for the dental and/or surgical services rendered by dentists for whom the Clinic is authorized to charge and bill. I have read, understand and agree to the terms of the "Parkrose Dental" Credit Policy. I understand that my obligation to pay all charges is not affected by the fact that I may have insurance benefits. If my insurance company fails to pay all or any portion of these charges in a timely manner for any reason, I will be responsible for all sums due and owing the Clinic.

_____ _____
Signature of Insured/Person Authorized to Consent Date

I hereby certify that I have witnessed the signatures of the patient and/or individual signing on behalf for the benefit of the patient on items 1 and 2 above.

_____ _____
Signature of Insured/Person Authorized to Consent Date

PARKROSE DENTAL

Thomas T. Tieu, DMD
3620 NE 122ND AVE • PORTLAND OR • 503.254.5575
parkrosedental.com

CREDIT POLICY

PATIENT RESPONSIBILITY: Patients are responsible for all charges resulting from treatment provided by Parkrose Dental. As a service to you we will bill most insurance carriers directly; however primary responsibility for the account is yours. Payment is due within thirty (30) days of statement billing unless other financial arrangements are made. Should your account be placed in a collection status, you will be responsible for all agency and/or legal fees incurred.

INITIAL VISIT: Patients are required to pay for their first appointment's charges at time of service in order to establish a credit history at this clinic. Individuals excluded from this policy are: HMO/PPO enrollees with current eligibility, CAPITOL members with proper PCP identification, Worker's Compensation claimants, and established families with good credit history. Exclusion from the above policy does not negate in whole or part patient's personal responsibility.

INSURANCE: You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically or dentally necessary" by your insurance company. Patient accepts all responsibility for understanding their applicable policy, and understands that deductibles, co-pay, covered and non-covered services are dependant and defined by patient's plan's governing plan documents. No statement or representation by any representative of Parkrose Dental. should be construed to replace or define patient's current coverage, actual insurance payment or expected patient responsibility. Please pay co-payments and coinsurance amounts as services are rendered. Allow amounts quoted by representatives of Parkrose Dental are estimation based on best available information; actual patient responsibility may vary from quoted estimates. The remaining balance must be paid within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. We will as a courtesy bill your primary insurance carrier for you and attempt to verify insurance. If current coverage cannot be verified, all applicable fees will be due at time of service. Providing correct insurance billing information is the responsibility of the patient. Patients are asked to bring their current insurance identification card to each appointment and valid identification. If payment cannot be made at each visit, notify the business office to make other arrangements.
HMO/PPO Plans: HMO/PPO co-payments are due at the time of each visit. HMO/PPO enrollees will not receive a monthly statement unless there is a balance owing from the patient.

Oregon/Washington Welfare and Capital Health Plan: Please bring your current medical card with you to each appointment. By signing the "Consent for Dental Services" patient accepts all responsibility for an unpaid fees.

Workers' Compensation: In order to file a Worker's Compensation claim, you will need the name of your insurance carrier, the date of your injury and your claim number, if available. Be certain to notify the registration desk at each appointment if your visit is due to an injury covered by Workers' Compensation.

Motor Vehicle or Other Liability Claims: Parkrose Dental. is unable to bill insurance carriers in liability claims. While we understand that settlement of these claims can take many months, full payment for the visit(s) or financial arrangements must be made at the time of service.

DIVORCED PARENTS: Parkrose Dental. will not be responsible for disputes between parents due to a divorce. The custodial parent or the parent who bring the child(ren) to the clinic will be responsible for the account of the child(ren). If the courts hold a specific parent responsible for providing health care, the dispute is between the parents and will not be arbitrated by Parkrose Dental.

REBILL/LATE CHARGES: All charges are due and payable within thirty (30) days of the first billing unless you arrange a budget payment with our Billing Department. A rebill fee of $5.00 will be charged for all outstanding balances over 30 days. Parkrose Dental reserves the right to apply applicable interest and late penalties to outstanding accounts in accordance with state and federal law. Guarantor agrees to bear all cost of collection and/or court costs and reasonable legal fees. Accounts assigned to collection will be charged a $150.00 collection fee.

CHECKS RETURNED FOR INSUFFICIENT FUNDS: It is our clinic's policy to charge all patients a $25.00 fee for checks that are returned unpaid by the bank. Until a good credit history can be established, all further payments must be made in cash.

MISSED APPOINTMENTS: If you cannot keep your appointment, please cancel twenty-four (24) hours prior to the scheduled time or a $50.00 "NO SHOW" fee may be charged to your account.

If you have any questions about the above policy, please speak with our Clinic Receptionist.

I have read and received a copy of the Credit Policy for Parkrose Dental. By consenting to receive dental services, I accept this credit policy for dental treatment with Parkrose Dental.

Patient's Signature:_____ Date:_____

Parent/Guardian (if patient is a minor):_____ Relationship to Patient:_____