Advantage Dental
From DentaQuest

Welcome, and thank you for selecting our dental healthcare team! We strive to provide the best possible dental care. To help us achieve this goal, please fill out these forms as completely as you can, in ink. If you have any questions or need assistance, please feel free to ask us. We would be happy to help!

Intake Form

Information provided on this form is not sold or used to spam you. It is only used for communication regarding your dental care, the patient portal and for your dental records.

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. Our clinic does not use this information to discriminate.

How did you hear about Advantage?

Check one & specify when applicable

- ☐ Internet
- ☐ Yelp
- ☐ Facebook
- ☐ Google Search
- ☐ Website
- ☐ Mailer
- ☐ Sign
- ☐ Radio Station_____
- ☐ Word of Mouth: -
  Name of patient who referred you
  _____
- ☐ Insurance
- ☐ Other Please specify:
  _____

Date (mm/dd/yyyy)	Date of Birth (mm/dd/yyyy)	Sex (choose one) ☐M ☐F ☐Other ☐Choose Not to Disclose	ODL#	SSN - -

Last Name	First Name	MI	Suffix (circle one) Sr/Jr/I/II/III

Address	City	State	Zip

Mailing Address (if different)	City	State	Zip

Race: ☐Caucasian ☐Black/African American ☐Hispanic/Latino ☐Other: _____ ☐Choose not to disclose

Please provide all phone numbers and email, but check the box next to your preferred form of communication

☐ Home Phone ☐ Cell Phone (text)

☐ Work Phone ☐ Email Address

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino	Occupation	Employer

Emergency Contact	Relationship	Home Phone	Cell Phone

Do you have Dental Insurance? YES NO If yes, who is your insurance carrier?

Primary Carrier	Policy Holder	Group Number	Subscriber I.D.	DOB	SS#
Secondary Carrier	Policy Holder	Group Number	Subscriber I.D.	DOB	SS#

Do you have Medical Insurance? YES NO If yes, who is your insurance provider?

Primary Carrier	Policy Holder	Employer Policy/Group Number	Subscriber I.D.	DOB

Primary Care Physician	Name	Address	City	Phone Number

Were you referred to this clinic? **YES** **NO** If yes, who referred you:_____

If you require a language interpreter specify language: _____

Did an interpreter help you with these forms? **YES** **NO**

If you are completing these forms for the patient, circle your relationship and print your name:_____

MOTHER FATHER GUARDIAN OTHER

OFFICE USE

Blood Pressure: _____/_____ Pulse: Height: Weight: Date:

DENTAL/HEALTH HISTORY

What is the reason for your dental visit today? EXAMINATION EMERGENCY CONSULTATION PROCEDURE

How would you describe your current dental problem? _____

Date of your last dental visit (Month/Year): _____ EXAM EMERGENCY CONSULTATION PROCEDURE OTHER: _____

Have you had any problems with previous dental treatment? **YES NO** If yes, please specify**:** _____

Do you have any clicking, popping, discomfort, or limited opening in the jaw? **YES NO** If yes specify: _____

How often do you brush your teeth? **NEVER SOMETIMES ONCE A DAY TWICE A DAY MORE THAN TWICE A DAY**

How often do you floss your teeth? **NEVER SOMETIMES ONCE A DAY ONCE A WEEK MORE THAN ONCE A DAY**

Do your gums bleed when you brush or floss? **NEVER SOMETIMES ALWAYS**

When was your last Hemoglobin A1c (HbA1c) (blood sugar test)? _____ What was the number? _____

Please state any questions or concerns about dentistry or your dental health: _____

Are you currently experiencing dental pain or discomfort?	**YES NO**	Do you have loose teeth?	**YES NO**
Are you unhappy with your smile or the appearance of your teeth?	**YES NO**	Do you have headaches, earaches, or neck pains?	**YES NO**
Do you want a brighter whiter smile?	**YES NO**	Are you worried about losing your teeth?	**YES NO**
Do you have problems with eating (trouble chewing, vomiting, etc.)?	**YES NO**	Do you clench, brux, or grind your teeth?	**YES NO**
Do you have bad breath/ halitosis, metallic taste, or unpleasant taste?	**YES NO**	Are your teeth sensitive to cold, hot, sweets or pressure?	**YES NO**
Do you have any obstacles to cleaning or caring for your teeth?	**YES NO**	Does food or floss catch between your teeth?	**YES NO**
Have you ever had a serious injury to your head or mouth	**YES NO**	Have you ever had orthodontic (braces) treatments?	**YES NO**
Do you have bridges or wear dentures or partials? If yes please fill out denture questionnaire	**YES NO**	Do you have swelling in or around your mouth, face, or neck?	**YES NO**

Are you taking, have you recently (within the last month**) taken, or are you supposed to be taking any medications? YES NO**
(Prescription, over the counter, diet supplements, vitamins, natural, or herbal**)**

If yes, please specify medication(s), dosage, and frequency:

Medication Prescription or Over the Counter			**Dosage/Frequency**	**Supplements** Diet supplements, vitamins (natural or herbal)	**Dosage/Frequency**
ASPIRIN	**YES**	**NO**	Last Dose:		

Do you have, or have you had any of the following? (Circle yes or no for each)

AIDS/HIV Positive	YES NO	Cortisone Medicine	YES NO	Hepatitis A	YES NO	Recent Weight Loss	YES NO
Alzheimer's Disease	YES NO	Diabetes	YES NO	Hepatitis B or C	YES NO	Renal Dialysis	YES NO
Anaphylaxis	YES NO	Drug Addiction	YES NO	Herpes	YES NO	Rheumatic Fever	YES NO
Anemia	YES NO	Easily Winded/Shortness of Breath	YES NO	High Blood Pressure	YES NO	Rheumatism	YES NO
Angina	YES NO	Emphysema	YES NO	High Cholesterol	YES NO	Scarlet Fever	YES NO
Arthritis/Gout	YES NO	Epilepsy or Seizures	YES NO	Hives or Rash	YES NO	Sexually Transmitted Disease	YES NO
Artificial Heart Valve	YES NO	Excessive Bleeding	YES NO	Human Papillomavirus (HPV)	YES NO	Shingles	YES NO
Artificial Joint	YES NO	Excessive Thirst	YES NO	Hypoglycemia	YES NO	Sickle Cell Disease	YES NO
Asthma	YES NO	Fainting spells/Dizziness	YES NO	Irregular Heartbeat	YES NO	Sinus Trouble	YES NO
Blood Disease	YES NO	Frequent Cough	YES NO	Kidney Problems	YES NO	Spina Bifida	YES NO
Blood Transfusion	YES NO	Frequent Diarrhea	YES NO	Leukemia	YES NO	Stomach/Intestinal Disease	YES NO
Breathing Problem	YES NO	Frequent Headaches	YES NO	Liver Disease	YES NO	Stroke	YES NO
Bruise Easily	YES NO	Developmental Disorder	YES NO	Low Blood Pressure	YES NO	Thyroid Disease	YES NO
Cancer	YES NO	Glaucoma	YES NO	Lung Disease	YES NO	Tonsillitis	YES NO
Chemotherapy	YES NO	Hay Fever	YES NO	Mitral Valve Prolapse	YES NO	Tuberculosis	YES NO
Chest Pain	YES NO	Heart Attack/Heart Failure	YES NO	Osteoporosis	YES NO	Tumor or Growths	YES NO
Circulatory Problems	YES NO	Heart Murmur	YES NO	Pain in Jaw Joints	YES NO	Yellow Jaundice	YES NO
Cold Sores/Fever Blisters	YES NO	Heart Pacemaker	YES NO	Parathyroid Disease	YES NO	Ulcers	YES NO
Congenital Heart Disorder	YES NO	Heart Trouble/Disease	YES NO	Psychiatric Care	YES NO		
Convulsions	YES NO	Hemophilia	YES NO	Radiation Treatment	YES NO		

PLEASE CIRCLE YOUR RESPONSES YES or NO TO INDICATE IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

Are you now, or have you been in the past year, under the care of a physician? **YES NO**

If yes, what is/are the condition(s) being treated? _____

Have you had an organ transplant? If yes, please specify: **YES NO**

HEART KIDNEY LIVER LUNG OTHER (SPECIFY): _____

Have you had an orthopedic total joint (e.g., hip, knee, elbow, finger) replacement? **YES NO**

If yes, what joint was replaced? _____ If yes, when (Month/Year)? _____

Have you ever had any radiation therapy or chemotherapy for a growth, tumor, or other condition? **YES NO**

If yes please specify: _____

In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)? **YES NO**

If yes please specify: _____

Have you taken, are you taking, or are you scheduled to begin taking: Oral bisphosphonates? **YES NO**
(Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid)?

If yes, what drug, dose, and frequency? _____

Have you taken, are you taking, or are you scheduled to begin taking:
Intravenous bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia), or Zoledronic Acid (Reclast, Zometa))? **YES NO**

If yes, what drug, dose and frequency? _____

If yes, what for? _____ If yes, when?_____

Have you had any serious illness not listed above? NO YES: _____

TOBACCO:

Do you use or have you used tobacco (smoking, snuff, chew, bidis)? **NEVER PAST CURRENTLY**

How interested are you in stopping? **VERY SOMEWHAT NOT INTERESTED**

DRUGS/ALCOHOL:

Do you use recreational drugs or prescription medication for non-medical reasons? **YES NO**

Do you use alcohol on a regular basis? **YES NO**

MOOD:

During the past two weeks, have you been bothered by little interest or pleasure in doing things? **YES NO**

During the past two weeks, have you been bothered by feeling down, depressed or hopeless? **YES NO**

ALLERGIES:

Are you allergic to any of the following? (circle all that apply)

Aspirin Penicillin Codeine Local Anesthetic Acrylic Metal Latex Sulfa Drugs Iodine Vicodin Other: _____

Do you normally take an antibiotic prior to dental treatment? **YES NO**

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 of Patient or Guardian: _____ Date: _____

WOMEN ONLY

Are you pregnant? If yes, number of weeks: _____ **YES NO** Are you nursing? **YES NO**

Would you like to become pregnant in the next year? **YES NO**

OFFICE USE | HEALTH HISTORY REVIEWED BY:

Provider's Signature Date

Advantage Dental
From DentaQuest

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name: _____ Date of Birth: ____/____/____

1. Authorization
I authorize Advantage Dental to use and disclose the PHI relevant to care for the patient to any of the referrals listed (referral list available upon request.) In addition, I authorize the release to the below named individual(s):

_____

2. Effective Period
This authorization for release of information covers the period of healthcare from: (Circle and Fill out option "A" or "B". Do not select both.)

A. _____ (date) to _____ (date) .

B. all past, present, and future periods.

3. Extent of Authorization
(Circle and Fill out option "A" or "B". Do not select both.)

A. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

B. ☐ I authorize the release of my complete health record with the exception of the following information:
- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, promotion or marketing, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires. If no date is specified, this authorization form shall expire one year from the date of the below signature.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization will be disclosed by the recipient and it is my intent that the information will no longer be protected by federal or state law.

ACKNOWLEDGEMENT

✘ _____ ***Signature of patient, parent, or legal guardian***

✘ _____ ***Printed name of patient, parent or legal guardian***

✘ _____ ***Relationship to patient***

Date: ____/____/____

T: (888) 468-0022 F: (541) 504-3907 442 SW Umatilla Ave. Redmond, OR 97756

STAFF INITIALS _____

PATIENT FINANCIAL POLICY

Our goal is to provide you and your family with optimal dental care, and to be a place where patients feel welcomed and valued. Our office strives to provide the highest quality dental care at affordable prices. Our dentist will diagnose treatment based on your dental health and not your insurance coverage. We encourage you to ask questions and to be involved in treatment decision, while we help educate you about your oral health and the importance of prevention

Kindly remember, you are fully responsible for all fees charged by this office regardless of your insurance coverage.

The purpose of this policy is to eliminate confusion or misunderstandings concerning financial arrangements offered by our office. If you have dental insurance, your portion is due at the time of service. As a courtesy, this office will file your insurance claim, but we will not guarantee any benefit. We will credit any such collections to the appropriate account. Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by you and your insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your insurance company. Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered.

1. For our patients on the Oregon Health Plan (OHP), the OHP will be billed for covered services. In the event a service is not covered by OHP, you will be informed prior to the service being performed.

2. Payment at the time of service is expected, including the estimated portion of the amount that insurance does not cover. Our office accepts the following payment methods: Cash, Check, All Major Credit Cards, and third party financial group offering a line of credit for dental fees, for those who qualify. We do not offer in house payment plans.

3. A statements for services rendered will be mailed to you monthly. Receipt of payment is expected within 30 days of the billing date on the statement. Payment should be mailed with the top portion of the statement to establish the proper crediting of the account. If your insurance company hasn't paid on a claim after 30 days, please contact them to find out why.

4. Your account is considered delinquent if the requested payment due is not received within 30 days of the billing date on the statement. If payment is not received, a late charge of 1½% per month ($1.00 minimum) may be assessed and will appear on the next statement. The annual percentage rate is 18%.

5. For any check that is returned for any reason, the original amount of the returned item plus a $35.00 charge will be billed to your account. We will not accept payments by check, debit card, or credit card from you in the future.

6. Patient understands and agrees that if they fail to make any of the payments for which they are responsible for, in a timely manner, patient will be responsible for all costs of collection monies owed, including court costs, collection agency fees, and attorney fees.

I have read and understand the financial policy of Advantage Dental Group, PC (Advantage Dental) and agree to all the terms described in it. I agree that a photocopy of the financial policy shall be considered as effective and valid as the original. Regardless of what insurance coverage patient has, patient is ultimately responsible for the timely payment of their account and patient herby authorize the payment of insurance benefits to be made directly to Advantage Dental Group, PC.

➢ _____

Signature of patient/Guardian *Date*

CONSENT TO DENTAL PROCEDURES, ADMINISTRATION OF ANESTHETICS, SEDATIVES AND THE RENDERING OF OTHER SERVICES

Patient: _____ Age: _____ Date: _____

I hereby authorize Advantage Dental, Advantage Dental Group, PC, Associate Dentists and/or such assistants as may be selected, to perform Routine Dental Care, a Comprehensive Exam or Limited Oral Evaluation plus any diagnostics including x-rays upon the above named and/or any other therapeutic procedure that his/her/their judgment may dictate to be advisable for the patient's well-being. I hereby acknowledge and agree that if my insurance does not cover the treatment authorized above or it is not covered by the Oregon Health Plan, I will be personally responsible for paying the financial charges for those services.

I authorize that any specimens, tissue or parts removed from the patient may be disposed of in accordance with established practice.

I further authorize the performance by any qualified person of any other services which are deemed to be necessary or advisable.

If in Associated Dentist's opinion, further observation of the above named is indicated after an anesthetic or procedure, the above named agrees to be transported by ambulance at his/her personal expense to a mutually satisfactory hospital in the local area, and to be admitted for observation and any necessary treatment.

If in Associated Dentist's opinion, the above named requires that services of a specialist, he/she agrees to accept the referral and will be responsible for any expense that may be incurred.

I certify that I have read this consent, or that it has been read to me, and that I understand the above. The nature and purpose of such operation(s), procedure(s), treatment(s), and/or services and the reasons why the same is (are) considered necessary or advisable have been explained to me.

➢ _____ _____

Signature of Patient (*or Person Authorized to Sign for Patient*)

_____

(*Relationship to Patient*)

Continuing Consent

Procedure:	Initials:	Date: