Dental Excellence

Changing Lives One Smile At A Time

670 Superior Court #101
Medford, OR 97504-6179
(541) 779-6170
Fax (541) 779-0989

ABOUT YOU

Today's Date:__________________ E-mail Address:________________________

NAME:____
LAST FIRST MI MR MRS MS DR

I prefer to be called:__________________________ Male Female

Birth date:___/___/___ AGE:_________ SS#__________________________

Home Address:____
APT / CONDO #

____
CITY STATE ZIP

Single Married Divorced Widowed Separated

HM # (____)______________________ Pager / Other #: ____________________

WK# (____)________________________Ext:_____ DL#:______________________

Employer: ____

Employer's Address: ____

How long there? ____________ Occupation: ___________________________

Where & When are best times to reach you? ___________________________

Whom may we thank for referring you? _______________________________

Other family members see by us: ___________________________________

Previous / Present Dentist: ____
(please circle)

Last Visit Date: ____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: ____________________________________

Insurance Co. Address: __________________________________

Insurance Co. Phone #: (____)____________________________

Group # (Plan, Local or Policy #) _________________________

Insured's Name: _________________ Relation:____________

Insured's Birth date:___/___/___Insured's SS#____________

Insured's Employer: ______________________________________

Employer's Address:_______________________________________

Secondary Dental Insurance

Insurance Co. Name: ____________________________________

Insurance Co. Address: __________________________________

Insurance Co. Phone #: (____)____________________________

Group # (Plan, Local or Policy #) _________________________

Insured's Name: _________________ Relation:____________

Insured's Birth date:___/___/___Insured's SS#____________

Insured's Employer: ______________________________________

Employer's Address:_______________________________________

SPOUSE INFORMATION

HIS / HER Name: ____

Employer: ____

Wk #: ________________________ Ext: _____ SS #: ______________

Birth date: ___/___/___ DL #: _________________________________

In the event of an emergency, is there someone who lives near you that we should contact?

HIS / HER Name:______________ Relation:______________

Wk #: (____)__________________ Hm #: (____)__________

Person Responsible for Account:_____________________________

Work #: (____)______________Ext:_____ Home #:(____)____________

Billing Address: ____

Relation: ________________________ SS #:_____________________

Employer: ______________________ DL#:______________________

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: ______________________________________

Wk #: (___)____________ Date of Last visit:__________

Medical History (continued)

Your current physical health is: **Good** **Fair** **Poor**

Are you currently under the care of a physician? Yes No

Please Explain:______________________________

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one:______________________________

Do you smoke or use tobacco in any other form? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #:__________

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y N	Anemia / Radiation Treatment		Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Bones / Joints/ Valves		Y N	Hepatitis
Y N	Arthritis		Y N	High / Low Blood Pressure
Y N	Asthma		Y N	HIV+ / AIDS
Y N	Blood Transfusion		Y N	Hospitalized for Any Reason
Y N	Cancer / Chemotherapy		Y N	Kidney Problems
Y N	Congenital Heart Defect		Y N	Mitral Valve Prolapse
Y N	Diabetes		Y N	Psychiatric Problems
Y N	Difficulty Breathing		Y N	Rheumatic / Scarlet Fever
Y N	Drug / Alcohol Abuse		Y N	Severe / Frequent Headaches
Y N	Emphysema / Glaucoma		Y N	Shingles
Y N	Epilepsy /Seizures / Fainting Spells		Y N	Sickle Cell Disease / Traits
Y N	Fever Blisters / Herpes		Y N	Sinus Problems
Y N	Heart Attack / Stroke		Y N	Tuberculosis (TB)
Y N	Heart Murmur		Y N	Ulcers / Colitis
Y N	Heart Surgery / Pacemaker		Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs / material that you are allergic to :__________________

____

Dental History

Why have you come to the dentist today?

____

____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: **Good** **Fair** **Poor**

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss?____ a day do you brush?____

Type of bristles? Hard Medium Soft

Have you ever taken Phen-Fen? Yes No
(also known as Redux or Pondimin)

If so when? ______________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials__________ Date:__________

Doctor's Comments:______________________________

MEDICAL HISTORY UPDATE

1. Date:__________ Comments:______________________________ Signature:__________________

1. Date:__________ Comments:______________________________ Signature:__________________

1. Date:__________ Comments:______________________________ Signature:__________________

RICHARD C. SCHMIDT, D.M.D., P.C.
ROBERT H. JOHNSON, D.D.S., P.C.
BLAIR TUDOR, D.M.D.

FINANCIAL RESPONSIBILITY

You are responsible for any balances after insurance payment. If you do not have insurance you are responsible for charges at the time of service.

FINANCE CHARGE: A finance charge is imposed on those charges not paid in full within 30 days of the date you were first billed for charges.

The FINANCE CHARGE is a periodic rate of 1.50% per month (ANNUAL PERCENTAGE RATE of 18%). There is a $1.00 minimum FINANCE CHARGE per month.

BILLING QUESTIONS OR ERRORS

If you believe you have been billed incorrectly, or you need more information regarding a transaction on your bill, write us on a separate sheet to 670 Superior Ct., #101, Medford, OR 97504 within 30 days. You may also contact us at 541-779-6170.
In your letter, please include the following information:

Your name and the patient's name (if other than yourself)
The dollar amount of the suspected error
Describe the error and explain why you believe there is an error

We ask that on the day of your appointment that you pay the percentage we estimate that will not be covered by your insurance company, as well as any deductible not yet met. If your insurance company has not paid on your claim within 45 days, we will ask you to pay the balance on the account in full. **Due to there being thousands of different insurance plans available, it is the responsibility of the patient, not the provider, to know what is covered or excluded from his/her plan.** That includes any waiting periods that may apply. It is also your responsibility to inform our office if your dental coverage was terminated or changed in any way. If we are unable to verify insurance benefits with the insurance company, the account will be considered private pay.

I acknowledge and agree that if no payment, either by myself or my insurance company has been received by Dental Excellence after 90 days from the first billing date that the account will be sent to collections, I acknowledge that if this account is placed in the hands of an attorney of collection agency, I will pay reasonable costs associated, which include court costs and attorney fees.

____

Signature Date

Dental Excellence

Richard C. Schmidt, D.M.D., P.C. • Robert H. Johnson, D.D.S., P.C. • Blair Tudor, D.M.D.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

•You May Refuse to Sign This Acknowledgement•

I, ______________________________ have received a copy of this office's Notice of Privacy Practices.

Please Print Name ____

Signature ____

Date ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)

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