City Dental

portlandcitydental.com
511 SW 10th, Suite 704 • Portland, OR 97205
portlandcitydental@gmail.com
(503)227-2883

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

What are your preferred pronouns?

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact: *

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment ☐ both ☐ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ both ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

In our continued commitment to provide the highest quality of dental care available to all of our patients, and to have those services comfortably affordable, we are pleased to offer you these options for payment.

. Care Credit
. 5% Accounting Courtesy for payment in full with cash or check
. Visa, Master Card, Discover, American Express

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

Patients are responsible for all charges resulting from care at our office. As a courtesy to you, we will process your insurance benefits in our office. Should insurance companies delay payment, you will need to participate in expediting payment. As patients, please be aware that there are many insurance companies, and different programs within those companies. Our staff cannot be expected to be "experts" on what is covered and what is not covered. The expectations of understanding one's plan falls on the shoulders of the patient.

I agree that I am fully responsible for the total payment of all procedures performed in this office. This includes any treatment that is not a benefit of any insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within (60) days of the date of service, regardless of whether or not my insurance benefits have been received. If for any reason, the estimated amount is not paid by your insurance company, it becomes your obligation.

Cancellation/No Show Policy: I understand that I will be billed $50 per half hour if I cancel with less than 48 hours' notice or do not arrive for my scheduled appointment.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Patient Photo Release

I hereby authorize Dr. Jason Bajuscak DMD and/or his employees to take photographs, slides and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs will be used as part of my dental record. I further understand and authorize that the photos can be used without my name or other identifying information for any lawful purpose, including education, demonstration, advertising, and/or web content. I do not expect compensation, financial, or otherwise for the use of these photos.

Please choose one of the three options listed below:

☐ I authorize use of any photos in any of the above situations.

☐ I do not authorize to have my face shown in any photos publicized, I only agree to have my teeth shown without any identifying features.

☐ I do not authorize to have my photos used for any other purpose than my patient record.

☐ * **By checking this box, I acknowledge that I have read and understand the above and have had all my questions answered to my satisfaction.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

_____

_____

Name and Relationship to Patient:

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Signature _____ **Date** _____

Response Date: _____

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Medical History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Albuterol
- ☐ Allergies
- ☐ Allergy:Alcohol
- ☐ Allergy:Aspirin
- ☐ Allergy:Azithromycin
- ☐ Allergy:Barbiturates
- ☐ Allergy:Clindamycin
- ☐ Allergy:Codeine
- ☐ Allergy:Ibuprofen
- ☐ Allergy:Latex
- ☐ Allergy:Local Anesth
- ☐ Allergy:Naproxin
- ☐ Allergy:Penicillin
- ☐ Allergy:Tetracycline
- ☐ AllergyCephalosporin
- ☐ Anemia
- ☐ Anxierty Disorder
- ☐ Arthritis
- ☐ Artif Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Back Problems
- ☐ Barbiturates
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependancy
- ☐ Chemotherapy
- ☐ Circulatory problem
- ☐ Cortisone Treatments
- ☐ Crohn's Disease
- ☐ Dental Anxiety
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Dizziness
- ☐ Easy Bleeding
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Hashimoto's Disease
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ MS
- ☐ Mental Disorders
- ☐ Mitral-V Prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant/Nursing
- ☐ Psoriasis
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shortness of breath
- ☐ Sinus Problems
- ☐ Sjogren's
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Swelling: feet/ankle
- ☐ Thyroid Problems
- ☐ Thyroid-hyper
- ☐ Thyroid-hypo
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Transplant
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Allergies not listed:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ☐ Yes ☐ No

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

☐ Yes ☐ No

Please list any medications you are currently taking, one medication per line:

Have you ever taken Fen-Phen or Redux?

☐ Yes ☐ No

Have you ever taken or are you taking any medications for bone density?

☐ Yes ☐ No

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Signature _____ **Date** _____

Response Date: _____

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Dental History Form

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Why are you changing dental offices? Please choose all the apply: *

☐ Location ☐ Personal experience ☐ Change in insurance ☐ Cost of services ☐ You were recommended
☐ Dentist retired/closed

Please explain:

_____

_____

_____

How long has it been since your last dental visit?

☐ 1 month ☐ 3 months ☐ 6 months ☐ 1 year
☐ 2 years ☐ 3 + years ☐ I have never been to a dentist

Previous dentist name and phone number:

_____

_____

Date of most recent exam and dental x-rays:

_____

_____

How did you find us?

☐ Recommendation ☐ Insurance website ☐ Google ☐ Yelp

Other: _____

Reason for your visit today: *

☐ Pain ☐ Cleaning ☐ Check-up ☐ Other

Please provide details:

_____

_____

_____

Please check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

Have you ever had a bad experience at the dentist? * ☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

Have you had any complications following dental treatment? * ☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

Have you had unfavorable reaction to dental anesthetic? * ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

What is your level of anxiety/stress/fear when going to the dentist? *

☐ None ☐ Mild ☐ Moderate ☐ Severe

Are your teeth sensitive to cold, hot? * ☐ Yes ☐ No

Do your gums bleed when you brush or floss? * ☐ Yes ☐ No

Do you grind your teeth? * ☐ Yes ☐ No

Have you ever been treated for Periodontal Disease? * ☐ Yes ☐ No

How often do you brush? *

☐ 1 x day ☐ 2 x day ☐ 3 x day ☐ Occasionally ☐ Other

If other, please explain:

_____

_____

How often do you floss? *

☐ Never ☐ Occasionally ☐ 1 x day ☐ 2(+) x day

Do you like your smile? * ☐ Yes ☐ No

If you could change your smile, what would you like to change? *

☐ The color of my teeth ☐ The shape of my teeth ☐ Close spaces in my teeth

☐ Change the position/alignment of my teeth ☐ Restore worn or broken teeth ☐ Other

If other, please explain:

_____

_____

_____

I am interested in:

☐ Cosmetic evaluation ☐ Teeth whitening ☐ Straight teeth ☐ Replacing missing teeth ☐ White fillings

☐ Home care ☐ Sedation ☐ Other

If other, please explain:

_____

_____

_____

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.

_____

_____

_____

_____

Signature _____ **Date** _____

Response Date: _____