# Willamette Valley Periodontics

2260 SW 2nd Street, McMinnville, OR 97128 phone 503.474.9888 fax 503.474.9889

## Patient Information

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

Gender(M/F):_____ Marital Status:_____ Birth Date:_____

E-Mail Address:_____

Address:_____
Street Apartment#

_____
City State Zip Code

Phone #'s: Home_____ Work_____ Cell_____

**How would you like us to confirm your upcoming appointments? Please circle one:**

**Email Text (cell phone carrier_____) Cell Home Work**

## Spouse or Responsible Party Information

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

Gender(M/F):_____ Marital Status:_____ Birth Date:_____

E-Mail Address:_____

Address:_____
Street Apartment#

_____
City State Zip Code

Phone #'s: Home_____ Work_____ Cell_____

## Dental Insurance Information

Name of Insured:_____
Last First MI

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

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name and Address: _____

**Secondary**

Name of Insured:_____
Last First MI

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

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name and Address: _____

## Additional Information

Referred By:_____ Phone #:_____
Hygienist's Name:_____

In case of an emergency, whom shall we contact:

Name:_____ Phone #:_____

WILLAMETTE VALLEY PERIODONTICS

# ADULT DENTAL HISTORY

## TODAY'S VISIT

What is the reason for your dental visit today? Examination Emergency Consultation Procedure
Specify: _____

## PAST DENTAL TREATMENT

YES NO DK Have you been to the dentist before?

If yes, how long ago was your last dental exam? Please circle below:
0-6 MONTHS 6-12 MONTHS 1-2 YEARS >2 YEARS

If yes, how long ago were your last dental x-rays? Please circle below:
0-6 MONTHS 6-12 MONTHS 1-2 YEARS >2 YEARS

If yes, how long ago was your last dental cleaning? Please circle below:
0-6 MONTHS 6-12 MONTHS 1-2 YEARS >2 YEARS

YES NO DK Do you have a history of tooth extraction or oral surgery?
Specify: Extractions Implants Jaw Surgery TMJ Surgery Trauma

YES NO DK Have you had any periodontal (gum) treatments?
Specify: Deep Cleaning Surgery

YES NO DK Do you have bridges or wear dentures or partials?
Specify: Bridges Dentures Partials

YES NO DK Have you ever had root canal treatment?

YES NO DK Have you ever had orthodontic (braces) treatment?

YES NO DK Have you had local anesthetic (lidocaine) for dental purposes?
YES NO DK If yes, have you experienced any problems? (needle anxiety, hard to numb, ect)

YES NO DK Have you had any problems associated with previous dental treatment?

YES NO DK Has fear ever prevented you from seeking dentalcare?

## DENTAL PROBLEMS (Signs/Symptoms)

YES NO DK Are you currently experiencing dental pain or discomfort?
If yes, is it causing headaches, earaches or neck pain?
Specify: Headaches Earaches Neck Pain

YES NO DK Are your teeth sensitive to cold, hot, sweets or pressure?
Specify: Cold Hot Sweets Pressure

YES NO DK Do you have problems with eating? Please circle below:
Specify: Trouble Chewing Swallowing Vomiting Other

YES NO DK Do you have swelling in or around your mouth, face, neck?
Specify: Mouth Face Neck

YES NO DK Do you have loose teeth?

YES NO DK Do you have any clicking, popping, discomfort, or limited opening in the jaw?
Specify: Clicking Popping Discomfort Limited Opening

# ADULT DENTAL HISTORY (Cont.)

## DENTAL PROBLEMS

YES NO DK Do you have or have you had sores or ulcers in your mouth?
If yes, location _____

YES NO DK Have you ever injured your face, jaws or teeth?

YES NO DK Are you unhappy with your smile or the appearance of your teeth?

YES NO DK Do you have a bad taste or bad breath?
Specify: Bad Taste Bad Breath

YES NO DK Do you experience dry mouth?

## DENTAL DISEASE PREVENTION (Oral hygiene)

How often and when do you brush your teeth? Please circle below:
Never Sometimes 1 x Week 1 x Day AM 1 x Day PM 2 x Day > 2 x Day

How often do you floss your teeth? Please circle below:
Never Sometimes 1 x Week 1 x Day > 1 x Day

Do your gums bleed when you brush or floss? Please circle below:
Never Sometimes Always

## ORAL HABITS

YES NO DK Do you clench, brux, or grind your teeth
Specify: Clench Brux/Grind Both

YES NO DK Do you chew on ice or potentially damaging objects (pencils, bottle caps, etc.)?
Specify: Ice Objects Both

WILLAMETTE VALLEY PERIODONTICS

# ADULT MEDICAL HISTORY

Name _____ Date _____

Date of Birth _____ Height in feet _____ inches _____ Weight (lbs) _____

Who referred you to us? _____

Please circle your responses (YES, NO, DK = Don't Know) to indicate if you have, have not or do not know if you have had any of the following diseases or problems.

## GENERAL MEDICAL INFORMATION

Name of pharmacy used _____

YES NO DK Are you, or have you been in the past year, seen by a primary care provider (regular doctor)?
If yes, please list name and Location _____

YES NO DK Are you seen by any medical specialists?
If yes, please list name(s) and location(s) _____

YES NO DK Do you have active tuberculosis or have you been exposed to anyone with tuberculosis?
Specify: _____

YES NO DK Have you had heart surgery?
If yes, please specify: Stents Valves Bypass (CABG)
Other _____
Date(s) and any complications _____

YES NO DK Have you had an organ/bone marrow transplant?
If yes, please specify: Heart Lung Kidney Liver BMT
Other _____
Date(s) and any complications _____

YES NO DK Have you had an orthopedic total joint replacement?
If yes, please specify: Hip Knee
Other _____
Date(s) and any complications _____

YES NO DK Are you required to pre-medicate? If so, for **what**? _____

YES NO DK Do you use a CPAP? If so, what kind of mask? _____

Do you now or have you ever had cancer? If yes, **how** was it treated?

- ☐ Surgery: diagnosis, site, when _____
- ☐ Radiation: diagnosis, site, when _____
- ☐ Chemotherapy: diagnosis, site, when _____
- ☐ Medication to prevent or treat bone complications:
  If yes, please specify: _____
- ☐ Xgeva (Denosumab) ☐ Aredia (Pamidronate) ☐ Zometa (Zoledronic Acid)
  Length of time taken _____

# ADULT MEDICAL HISTORY (Cont.)

## GENERAL MEDICAL INFORMATION

YES NO DK Have you had any serious illness, surgery, or been hospitalized? If yes, how long ago?
- ☐ 0-12 Months Specify: _____
- ☐ 1-5 Years Specify: _____
- ☐ 5 years Specify: _____

YES NO DK Problems with general Anesthesia:
- ☐ Difficult intubation
- ☐ Malignant hyperthermia
- ☐ Prolonged/difficulty waking
- ☐ Post-operative nausea and vomiting
- ☐ Other (specify) _____

YES NO DK Do you use or have you used tobacco products?

If yes, please specify: Cigarettes E-cigarettes Cigars Pipes Hookah Snuff Chew Marijuana Other (specify) _____

PAST: When did you stop? _____ How many years of use? _____

CURRENT:
- ☐ >10 per day
- ☐ <10 per day
- ☐ Occasionally. For how many years? _____

How interested are you in stopping? Very Somewhat Not Interested

YES NO DK Do you drink alcoholic beverages? If yes, daily? YES NO DK

How many drinks per week? _____

YES NO DK Do you use or have you used street drugs, prescription or other substances for recreation purpose?

Specify:
- ☐ PAST
- ☐ CURRENT Are you dependent? YES NO DK Last Use: _____

Specify:
- ☐ COCAINE
- ☐ ECSTASY
- ☐ HEROIN
- ☐ MARIJUANA
- ☐ METH
- ☐ OPIOIDS
- ☐ Other (specify) _____

# ADULT MEDICAL HISTORY (Cont.)

## MEDICAL CONDITIONS

Do you have (or have you had) any of the following diseases, problems, or symptoms?

Eye/Ear/Nose/Throat Problem
YES NO DK
If yes, please specify:
☐ Vision problems
  ☐ Corrective lenses
  ☐ Cataracts
  ☐ Glaucoma
    ☐ Narrow angle/Open angle
☐ Hearing impairment
☐ Hay fever/seasonal (allergic rhinitis)
☐ Other: _____

Heart/Blood Pressure Problem
YES NO DK
If yes, please specify:
☐ High blood pressure
☐ High cholesterol/high triglycerides
☐ Infective endocarditis
☐ Congenital heart defect/disease
☐ Angina (chest pain)
☐ Heart attack
☐ Heart failure
☐ Coronary heart disease
☐ Arrhythmia (irregular heart beat)
☐ Pacemaker/Implanted defibrillator
☐ Other: _____

Breathing/Lung Problem
YES NO DK
If yes, please specify:
☐ Asthma
☐ Emphysema/COPD
☐ Sinusitis
☐ Bronchitis
☐ Pneumonia
☐ Obstructive sleep apnea
  ☐ Use CPAP/BiPAP
  ☐ Surgical correction
  ☐ Oral appliance
☐ Other: _____ ___

Eating Disorder
YES NO DK
If yes, please specify:
☐ Bulimia
☐ Anorexia
☐ Other: _____ ___

Stomach/Intestine/Liver Disorder
YES NO DK
If yes, please specify:
☐ Acid reflux (GERD)
☐ Ulcers
☐ Crohn's disease
☐ IBS (Irritable Bowel Syndrome)
☐ Ulcerative colitis
☐ Celiac disease
☐ Hepatitis
  ☐ A ☐ B/D ☐ C
☐ Other: _____

Kidney/Urinary Disorder
YES NO DK
If yes, please specify:
☐ Chronic kidney disease
☐ Renal failure/Dialysis
☐ Bladder problems
☐ Urinary incontinence
☐ BPH (Benign Prostate Hypertrophy)
☐ Other: _____

Muscle/Bone Disorder
YES NO DK
If yes, please specify:
☐ Osteoarthritis
☐ Osteoporosis
☐ Osteopenia
☐ Gout
☐ Temporomandibular joint disorder
☐ Fibromyalgia
☐ Other: _____

Neurologic/Nerve Problem
YES NO DK
If yes, please specify:
☐ Stroke
☐ TIA (Transient Ischemic Attack)
☐ Seizures/Epilepsy
☐ Multiple sclerosis
☐ Parkinson's disease
☐ Neuropathies (tingling, numbness)
☐ Dementia/Alzheimer's (memory loss)
☐ Autism
☐ Headache
☐ Other: _____

Skin Problem
YES NO DK
If yes, please specify: _____
_____

Mental Health Disorder
YES NO DK
If yes, please specify:
☐ Bipolar disorder
☐ Depression
☐ Schizophrenia
☐ PTSD (Post Traumatic Stress Disorder)
☐ ADD/ADHD (Attention Deficit Disorder)
☐ Generalized anxiety disorder
☐ Panic attacks
☐ Other: _____

Diabetes/Endocrine Disorder
YES NO DK
If yes, please specify:
☐ Diabetes
  ☐ Type 1 ☐ Type 2
☐ Thyroid problems
  ☐ Hypothyroidism (low)
  ☐ Hyperthyroidism (high)
☐ Other: _____

Immune System Disorder
YES NO DK
If yes, please specify:
☐ Lupus erythematosus
☐ Rheumatoid arthritis
☐ Siogren's syndrome
☐ Other: _____

Infectious Disease
YES NO DK
If yes, please specify:
☐ HIV/AIDS
☐ STD (Sexually Transmitted Disease)
☐ Cold sores
☐ Other: _____

Do you have any other problem, disease or condition not listed above?
If yes, please specify:
_____
_____
_____
_____
_____

# ADULT MEDICAL HISTORY (Cont.)

## FEMALES ONLY

YES NO DK Are you or could you be pregnant?
If yes, number of weeks _____ and due date _____

YES NO DK Are you nursing?

YES NO DK Are you taking any of the following?
Specify: Birth Control Fertility Drugs Hormone Replacement

## ALLERGIES TO DRUGS, LATEX, METALS OR FOODS

YES NO DK Are you allergic to or have you had a reaction to any of the following?

- ☐ Local anesthetics (Lidocaine/Epinephrine)
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other antibiotics Specify: _____
- ☐ Aspirin
- ☐ Advil (Ibuprofen)
- ☐ Tylenol (Acetaminophen)
- ☐ Codeine
- ☐ Opioids (hydrocodone, oxycodone)
- ☐ Chlorhexidine mouth rinse (Peridex/Periguard)
- ☐ Other medication(s) Specify: _____
- ☐ Latex (rubber)
- ☐ Metals/jewelry (nickel/chrome)
- ☐ Dietary allergies

Type of reactions to above: _____

## MEDICATIONS

YES NO DK Are you taking, or are you supposed to be taking any medications - prescription, over the counter, dietary supplements, herbal medicine or vitamins? If yes, please list below.

| Medications or Supplements<br>Prescription, over-the-counter, dietary supplement, herbal medicines and vitamins | Dose<br>(mg) | How Often?<br>Once a day, twice a day, etc. | Reason for Use | Date Started |
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WILLAMETTE VALLEY PERIODONTICS

**FINANCIAL STATEMENT**

In our continued commitment to provide you with quality dental care and to offer affordable services, we are asking that you pay your estimated patient portion at time of service. If you have dental insurance we will be happy to assist you in billing them.

When appointments are scheduled, we have ***reserved*** that time for you. If the appointment made is not rescheduled with 48 hours' notice or the appointment is missed we will charge a $50.00 fee to your account and ask that you put a credit card on file for future appointments. If you fail a second time to reschedule with less than 48 hours' notice or miss your appointment we will charge the card on file the full fee of your appointment.

We accept the following as forms of payment:

**Cash**
**Check**
**Debit Card**
**Credit Card: Visa, MasterCard, American Express or Discover**
**CareCredit® Financing**

Patient Acknowledgement:

*I understand the financial agreement regardless of insurance I am responsible for the balance of my account.*

_____

Patient Name Name of Responsible Party

_____

Signature of Responsible Party Date

2260 SW 2nd ST MCMINNVILLE OREGON 97128 T: 503 474 9888 F: 503 474 9889

WILLAMETTE VALLEY PERIODONTICS

## PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA'S requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Oregon Law requires us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connections with; a defense to a claim challenging our profession competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

**For Office Use Only**

☐ Patient refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify)

_____ _____

Office Personnel (signature) Office Personnel (print name)

## PATIENT ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (Please Print)

Date: _____

****We have audio /video surveillance cameras throughout the office.**

**Please initial for acknowledgement _____****