Patient Profile

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Date _____

Name _____

Name and relation (*if filling this out for a patient*)_____

_____

Email _____

Nickname/I prefer to be called_____

☐ Male ☐ Female

Birthday _____Age ____ SS # _____

Home Address _____

_____

Mailing Address *(if different from above)*_____

_____

☐ Single ☐ Divorced ☐ Separated

☐ Married ☐ Widowed ☐ Partner

Home Phone # _____ Cell # _____

Work Phone # _____ Extension _____

Employer _____

Employer Address _____

Occupation _____

Best # to reach you? _____

Best time to reach you? _____

Whom may we thank for referring you? _____

Other family member(s) seen by us? _____

Would you prefer to be contacted via:

☐ Text ☐ Email ☐ Phone

Spouse Information

Name _____

Employer _____

Email _____

Birthday _____ SS # _____

Work Phone # _____ Cell Phone #_____

Account Information

Person responsible for payment if other than patient

_____

Relation _____ SS # _____

Billing Address _____

Employer _____

Work Phone # _____ Extension _____

Home # _____ Cell # _____

Email _____

Emergency Contact

In the event of an emergency, is there someone who we should contact?

Name _____

Relation _____

Phone # _____

PONDEROSA
DENTAL ARTS

Phone: 503.656.6464 **Fax:** 503.557.4677

1174 Molalla Ave, Oregon City, OR 97045

PonderosaDentalArts.com

Insurance / Payment

Primary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Name _____

Address _____

_____

Phone _____

Group or Policy # _____

Insured's Name _____

Relation _____

Insured's Birthdate _____ Insured's ID # _____

Insured's Employer _____

Secondary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Name _____

Address _____

_____

Phone _____

Group or Policy # _____

Insured's Name _____

Relation _____

Insured's Birthdate _____ Insured's ID # _____

Insured's Employer _____

I understand that I am responsible for payment of service rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I authorize the insurance payment to be made directly to this office.

_____ _____

Signature Date

_____

Print Name

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

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Patient History

Medical History

Patient's Name _____

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

If so, what condition is being treated? _____

_____

Physician's Name _____

Phone # _____

Date of last visit _____

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

Joint replacement: Have you had an orthopedic total-joint replacement (hip, knee, elbow, finger, shoulder)? ☐ Yes ☐ No

Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, have you been treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?

☐ Yes ☐ No

Date treatment began _____

Have you ever taken Fosamax or any other bisphosphonate?

☐ Yes ☐ No

For women: Are you using a prescribed method of birth control?

☐ Yes ☐ No

Are you, or could you be, pregnant? ☐ Yes, week # _____ ☐ No

Are you nursing? ☐ Yes ☐ No

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

_____

_____

_____

Do you have or have you ever had any of the following?

Frequent, heavy snoring ☐ Yes ☐ No

Significant daytime drowsiness ☐ Yes ☐ No

Tendency to stop breathing while sleeping ☐ Yes ☐ No

Shortness of breath when waking up ☐ Yes ☐ No

Not feeling refreshed in the morning after sleep ☐ Yes ☐ No

Morning headaches ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Yes	No	
☐	☐	Abnormal bleeding
☐	☐	Alcohol/drug abuse
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Artificial bones/joints/valves
☐	☐	Asthma
☐	☐	Autoimmune disease
☐	☐	Blood transfusion
☐	☐	Bronchitis
☐	☐	Cancer/chemotherapy/ radiation therapy
☐	☐	Cardiovascular disease
☐	☐	Chest pain upon exertion
☐	☐	Chronic pain
☐	☐	Colitis
☐	☐	Congenital heart defect
☐	☐	Congenital heart disease (CHD)
☐	☐	Unrepaired, cyanotic CHD
☐	☐	Repaired CHD (completely) in last 6 months
☐	☐	Repaired CHD with residual defects
☐	☐	Congestive heart failure
☐	☐	Damaged valves in heart
☐	☐	Diabetes (Type I or II)
☐	☐	Difficulty breathing
☐	☐	Eating disorder
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Excessive urination
☐	☐	Fainting spells
☐	☐	Frequent headaches
☐	☐	Gastrointestinal disease
☐	☐	G.E. reflux/persistent heartburn
☐	☐	Glaucoma
☐	☐	Hay fever
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	Heart surgery
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High blood pressure
☐	☐	HIV/AIDS
☐	☐	Hospitalization
☐	☐	Kidney problems
☐	☐	Jaundice
☐	☐	Liver disease
☐	☐	Low blood pressure

Neurological disorders: If yes , specify

_____

Mental health disorders: If yes , specify

_____

Recurrent infections: If yes, specify type of infection

_____

Yes	No	
☐	☐	Malnutrition
☐	☐	Mitral valve prolapse
☐	☐	Night sweats
☐	☐	Osteoporosis/osteopenia
☐	☐	Other congenital heart defects
☐	☐	Pacemaker
☐	☐	Persistent swollen glands in neck
☐	☐	Previous infective endocarditis
☐	☐	Psychiatric treatment
☐	☐	Radiation treatment
☐	☐	Rheumatic arthritis
☐	☐	Rheumatic heart disease
☐	☐	Rheumatic/scarlet fever
☐	☐	Seizures
☐	☐	Severe headaches/migraines
☐	☐	Severe or rapid weight loss
☐	☐	Sexually transmitted disease
☐	☐	Shingles
☐	☐	Sickle-cell disease/traits
☐	☐	Sinus problems
☐	☐	Sleep disorder
☐	☐	Stroke
☐	☐	Systematic lupus erythematosus
☐	☐	Thyroid problems
☐	☐	Tuberculosis (TB)
☐	☐	Ulcers
☐	☐	Venereal disease

Continued on next page →

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Patient History Cont'd

Medical History Cont'd

Please list any prescription drugs or over-the-counter or herbal supplements you are taking.

_____

_____

_____

_____

Are you allergic, or have you had a reaction, to any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Jewelry	☐	☐	Tetracycline
☐	☐	Anesthetics	☐	☐	Latex	☐	☐	Sulfa
☐	☐	Local anesthetics	☐	☐	Metals	☐	☐	Animal food
			☐	☐	Penicillin	☐	☐	Iodine
						☐	☐	Codeine

Please list any other drugs/materials you are allergic to:

_____

_____

_____

_____

Dental History

Present/previous dentist _____

Date of last visit _____

What is the reason for your dental visit today? _____

_____

Do you need antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums ever bleed? ☐ 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 or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

How many times a week do you floss? _____

How many times a week do you brush? _____

Do you use an electric toothbrush? ☐ Yes ☐ No

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

Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature _____ Today's Date _____

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DENTAL ARTS

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1174 Molalla Ave, Oregon City, OR 97045
PonderosaDentalArts.com

No Show / Missed Appointment Policy for Ponderosa Dental Arts

When our office books your appointment, we are reserving a dedicated chair and time slot just for you. If you must reschedule your appointment, please provide us with at least 24 hours' notice. This makes it possible for us to give your forfeited time slot to another patient who is waiting to have an appointment.

There is a charge of $50 per hour for not showing up for scheduled appointments.
Repeated cancellations or issued appointments will result in loss of future appointment privileges.

Financial Policy for Ponderosa Dental Arts

We are committed to support you in understanding your dental health and will always present you with the best dental solutions possible to treat your personal situation. To make these affordable, we offer the following payment options:

Cash, all major credit cards, Care Credit Financing and person check ($35 returned check fee).

We will, as a courtesy, process your insurance claims in our office. We can bill most standard insurance companies, although we may not be contracted with your plan. It is your responsibility to understand your insurance policy and know if you have used any benefits prior to coming to our office.

1) We will estimate as closely as possible your insurance coverage, but the actual payment from your insurance carrier may differ.
2) If your insurance denies coverage or does not pay for any reason, you are responsible for any and all charges incurred in our office.
3) Please remember your co-pay, deductible, and estimated portion are due at time of service.

All questions regarding your insurance must be addressed to your insurance carrier. Your insurance policy is a contract between you, your employer and the insurance company.

Balances older than 90 days will be sent to collections. Finance charges of 1.5% accrue after 60 days.

Thank you for trusting us with your dental care. Any financial questions may be directed to our Office Administrator, Lecia, at 503-656-6464.

Signature _____ **Date** _____

PONDEROSA
DENTAL ARTS

Dr. Eric Berkner, DMD | 1174 Molalla Ave., Oregon City, OR 97045 | 503-656-6464

Notice of Privacy Practices

PONDEROSA
DENTAL ARTS

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you give us written authorization to use your health information or to disclose it to anyone for any purpose. If your give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $_____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager
Telephone: 503-656-6464
Fax: 503-557-4677
E-mail: office@ponderosadentalarts.com
Address: 1174 Molalla Ave., Oregon City, OR 97045

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment.

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

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) _____

Request for Release of Dental Records

Fill this out only if you have current records to be transferred.

I,_____, hereby grant permission to

_____ (previous Dentist name) to release

information related to my health history, status and treatment and copies of my dental record, x-rays,

periodontal charting, crown/bridge seat dates and any test results to:

E-mail: office@ponderosadentalarts.com

Fax: 503-557-4677

Ponderosa Dental Arts, PC
Dr. Eric Berkner, DMD
1174 Molalla Avenue
Oregon City, OR 97045

Signatures of all patients to be transferred:

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

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