Welcome to Soft Touch Dental

ABOUT YOU

Today's Date:_____ E-mail Address:_____

Name:_____ I prefer to be called_____ □Male □Fema
Last First Mi

Birthdate __/__/__ Age:_____ Social Security #:_____ □Single □Married □Divorced □Separated □Widowe

Home Adress:_____
Street City State Zip

Home Phone #:(__)_____ Cell #:(__)_____ Work Phone #: (__)_____ Ext:_____

Employer:_____ How Long There?_____ Occupation:_____

Employer's Address:_____
Street/PO Box City State Zip

Person Responsible For Account

Name: _____Relation: _____ Home Phone #: (__)_____ Social Security#:_____

Employer:_____ Work Phone #: (__)_____Ext:___ Drivers License #:_____

INSURANCE INFORMATION

Primary Insurance

Dental Coverage? □Yes □No

Insurance Co. Name:_____ Phone#:(__)_____ Group # (Plan, Local or Policy#):_____

Insurance Co. Name:_____
Street/PO Box City State Zip

Insured's Name:_____ Insured's SSN#:_____ Insured's Birthdate __/__/__ Relation:_____

Insured's Employer:_____ Employer's Address:_____
Street/PO Box City State Zip

Secondary Insurance

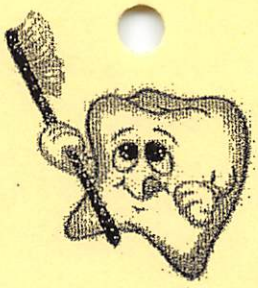
Dental Coverage? □Yes □No

Insurance Co. Name:_____ Phone#:(__)_____ Group # (Plan, Local or Policy#):_____

Insurance Co. Name:_____
Street/PO Box City State Zip

Insured's Name:_____ Insured's SSN#:_____ Insured's Birthdate __/__/__ Relation:_____

Insured's Employer:_____ Employer's Address:_____
Street/PO Box City State Zip



Welcome to Soft Touch Dental

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you **Pregnant?** ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

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, PARENT, or GUARDIAN _____ DATE _____

Soft Touch Dental, P.C.
1301 N.E. Broadway
Portland, Oregon 97232
503-249-1100

CONSENT FOR DENTAL PROCEDURE

I consent to the following dental procedure:

Exam and X-rays

Dentists and/or their staff have explained to me the procedure or treatment to be provided. I understand their explanation to my satisfaction. I am aware that alternative procedures and/or other methods of treatment may be available. I also understand that there are inherent risks to treatment as well all risks to postponing or declining any recommended treatment. I acknowledge that no guarantee or assurance has been made about the results of these recommended procedures or treatment.

Additionally, dentists or staff has asked me if I wanted a more detailed explanation of the recommended treatment. I attest to the fact that if I requested such additional explanation, it was given and all of my questions have been satisfactorily answered.

An informed patient is more likely to select better health care options, follow post-operative instructions more carefully, recover faster and experience fewer complications that an uninformed patient.

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

Signature of patient/guardian/caregiver authorized to give consent. Date

Witness Date

Soft Touch Dental, P.C.

FINANCIAL OPTIONS

IN ORDER TO BETTER SERVE YOU, WE OFFER THE FOLLOWING FINANCIAL OPTIONS:

Please sign one of the financial options below. Thank You.

1. NON-INSURED- Payment is due at the time services are performed. (A 5% discount will be given for payments made in full at least 1 day prior to proposed treatment, by cash or credit/debit card. The discount is allowed only for our regular fees. Does not apply to coupons or discounted fees.)

   Patient Signature _____

2. Upon Request, we have a NO INTEREST payment plan available through Care Credit Services to be paid in 12 monthly installments. The Minimum amount to be financed is $300. There isn't a penalty for early payoff. Applying takes 10 minutes. All payments will be made to Care Credit. Ask for an application at the front desk.

   Patient Signature_____

3. EMPLOYER BASED INSURANCE PLANS- We will, according to the perimeters provided us by you and your insurance company, ESTIMATE your dental benefits. We will also ESTIMATE your personal portion to pay at time of service. If your insurance company pays differently for any reason than estimated, it is understood that you are responsible to pay any remaining balance within 30 days of notification by your insurance company or from our billing service.

   Patient Signature_____

4. DISCOUNTED INSURANCE PLANS- In order to qualify for the discount benefit of your plan it is understood that you must pay your portion at time of service.

   Patient Signature_____

5. OREGON HEALTH PLAN- OHP patients will be financially responsible for any treatment NOT covered by their insurance due to lapse in coverage and is no longer covered by Medicaid.

   Patient Signature_____

Soft Touch Dental, P.C.

SECTION A: THE PATIENT.

Name: _____.

Address _____.

Telephone _____ E-mail _____.

Patient Number _____ Social Security Number _____.

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____.

If a personal representative signs this authorization on behalf of the individual complete the following:

Personal Representative's Name:

Relationship to Individual: _____.

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your Good faith effort to obtain the individual's signature on this form: _____.

Describe the reason why the individual would not sign this form. _____.

_____.

SIGNATURE

I attest that the above information is correct.

Signature: _____ Date _____.

Print name: _____ Title _____.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Soft Touch Dental, P.C.

Policy on Broken Appointment

- Broken Dental appointments cause a waste of valuable professional time and deprive others of treatment. It is your responsibility to report on time for your appointments.

- If you MUST cancel an appointment, notify our office at least twenty-four hours in advance. (Leaving a voicemail is also acceptable.)

- If during the course of treatment you break an appointment without twenty-four hours prior notification, you will be placed on our **Same Day Only Policy**. THERE ARE NO EXCEPTIONS TO THS POLICY. Once placed on Same Day you must make 4 consecutive appointments without missing any to be removed from same day scheduling.

- **Same Day Policy**- once placed on Same Day you will need to call in on a day you know you're available and see if there are any openings that day to schedule your needed appointment. **** IF you Cancel or Fail to show up to your Same Day appointment you will be dismissed from the practice and will need to seek treatment elsewhere.**

Signing this statement does not constitute agreement or disagreement with the policy described. Signing merely implies that you have been informed of our office policy regarding broken dental appointments.

I HAVE READ AND UNDERSTAND THE ABOVE:

Signature of parent or patient Date