

# WELCOME TO SOFT TOUCH DENTAL

## ABOUT YOU

Today's Date: \_\_\_\_\_ E-mail Address \_\_\_\_\_

Name: \_\_\_\_\_ I prefer to be called \_\_\_\_\_  Male  Female  Other  
Last First MI

Birth date: \_\_\_/\_\_\_/\_\_\_/ Age; \_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Separated  Divorced  
 Widowed

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Employer: \_\_\_\_\_ How Long There? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street/PO Box City State Zip

### - Person Responsible For Account -

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_ Driver LIC: \_\_\_\_\_

## INSURANCE INFORMATION

### - Primary Insurance -

Insurance Co. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Group# (Plan-Local or Policy#) \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_ Insured's Birth date: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Street PO Box City State Zip

Dental Coverage: \_\_\_ Yes \_\_\_ No

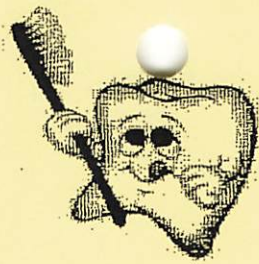
### - Secondary Insurance -

Insurance Co. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Group Plan-Local or Policy#: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_ Insured's Birth date: \_\_\_\_\_ 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 <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> 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 than 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 on 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. No coupons or discounted fees will be discounted.)

Patient Signature \_\_\_\_\_

2. **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 you billing services.**

Patient Signature \_\_\_\_\_

3. **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 \_\_\_\_\_

4. **OREGON HEALTH PLAN – OHP patients will be financially responsible for any treatment NOT covered by their insurance due to lapse in coverage, non-covered benefits, or failure to comply with Oregon state regulations at the time of service.**

**WE DO NOT EXCEPT PERSONAL CHECKS AS FORM OF PAYMENT**

Patient Signature \_\_\_\_\_

# Soft Touch Dental

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Notice of Privacy Practices.

The Notice of Privacy Practices explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Notice of Privacy Practices, please feel free to direct these to our Privacy/Security Officer at any time. The name and contact number of the Privacy/Security Officer is listed on your copy of the Notice of Privacy Practices

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Patient to complete this section*

I have received a copy of the Notice of Privacy Practices for this organization on today's date.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*If patient is unable to acknowledge receipt, staff member providing notice to complete this section*

The Notice of Privacy Practices was provided to

Patient Name: \_\_\_\_\_ On \_\_\_\_\_

The patient was unable to acknowledge receipt of the Notice of Privacy Practices for the following reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_

*File this form in the patient's chart*

# **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 Prior to opening on the day of your appointment is also acceptable.)
- IV Sedation appointment require a 7 day notice to be canceled or rescheduled
- 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**. 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.
- If you have a disability under state or federal law and the application of this policy presents a hardship to your ability to obtain dental services from our clinic then you can request an accommodation by contacting the Corporate Manager at (503) 249-1100

**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