Welcome to Barney Family Dental and thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care and achieve the smile you desire. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask – we are happy to help!

Date:

PATIENT INFORMATION

Name: ________________________________ Preferred Name: ________________

Address: ________________________ City: ____________ State: ______ Zip Code: __________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Receive Text Reminders? Y N Status: Single: ___ Married: ___ Divorced: ___ Widowed: ___ Other: ___

Date of Birth: __________ Age: ______ Social Security Number: ______________ Sex: M F

Email (contact purposes only): ______________________________ Receive Email Reminders? Y N

Whom may we thank for referring you? ______________________________

DENTAL INSURANCE

PRIMARY CARRIER: ________________________ Phone: __________ Employer: ______________

Subscriber: ______________________ Date of Birth: __________ Relationship to Patient: __________

Subscriber's SSN: ________________ Group #: ______________ ID#: ________________

SECONDARY CARRIER: ________________________ Phone: __________ Employer: ______________

Subscriber: ______________________ Date of Birth: __________ Relationship to Patient: __________

Subscriber's SSN: ________________ Group #: ______________ ID#: ________________

RESPONSIBLE PARTY INFORMATION (IF UNDER 18):

Person Financially Responsible for Account: ______________________________

Employer : ______________ Occupation: ______________ Phone: ______________

Spouse's Name: ______________________ Phone: ______________

EMERGENCY CONTACT: ______________________________

Phone Number: ______________ Relationship to Patient: ______________

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OUR FINANCIAL POLICY & CONSENT FOR TREATMENT

The following is a statement of our Financial Policy and Consent for Treatment, which we require you read and sign prior to any treatment performed. Please let us know if you have any questions.
Thank you!

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We realize every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget. Please note however, that payment in full is expected at the time of service. Barney Family Dental gladly accepts cash, checks and all major credit cards.
If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive full benefits of your coverage; however, we cannot guarantee any estimated coverage. Your insurance policy is an agreement between you and the provider; therefore, we ask that all patients be directly responsible for all outstanding charges. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you will be held responsible for payment at that time.

CONSENT FOR TREATMENT

I hereby authorize Dr. Barney or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize Dr, Barney to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required, to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to Dr. Barney or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used to disclose and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that **payment is due, in full, at the time of service** unless other arrangements have been made in advance. In the event payments are not received by the agreed upon dates, I understand that a 1.75% monthly finance charge (21% per year), will be added to any remaining account balance over 90 days. If required, I also understand a check of my credit history may be obtained.
In the event that I do not pay my account in a timely matter, I understand that my account may be turned over to a 3rd party collections agency and I will be responsible for any additional fees associated with the pursuit of my delinquent account.

The adult accompanying a minor and the parents (or legal guardian) are responsible for full payment.

MISSED & CANCELLED APPOINTMENTS

Per our office policy, Barney Family Dental reserves the right to charge $50.00 for missed and canceled appointments with less than 24 hours notice. With respect to our office and the patients we care for, please help us better serve you by keeping your scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

X____
(PLEASE PRINT FULL NAME)

X____ Date: _________________________
(Patient or Responsible Party Signature)

MEDICAL HISTORY

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: ____________________________

Do you take, or have you taken, Phen-Fen or Redux? __ Yes __ No If yes, please explain: ____________________________

Are you on a special diet? __ Yes __ No If yes, please explain: ____________________________

Are you taking any medications, pills or drugs? __ Yes __ No If yes, please list: ________________________________

____

WOMEN ONLY: Are you: Pregnant/Trying to get 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 Anesthetic __Other: (please list) ____

Please check all that apply:

AIDS/HIV Positive	__ Yes	__ No	Emphysema	__ Yes	__ No	Leukemia	__ Yes	__ No
Alzheimer's disease	__ Yes	__ No	Epilepsy or Seizures	__ Yes	__ No	Liver Disease	__ Yes	__ No
Anaphylaxis	__ Yes	__ No	Excessive Bleeding	__ Yes	__ No	Low Blood Pressure	__ Yes	__ No
Anemia	__ Yes	__ No	Excessive Thirst	__ Yes	__ No	Lung Disease	__ Yes	__ No
Angina	__ Yes	__ No	Fainting/Dizzy Spells	__ Yes	__ No	Mitral Valve Prolapse	__ Yes	__ No
Arthritis/Gout	__ Yes	__ No	Frequent Cough	__ Yes	__ No	Psychiatric Care	__ Yes	__ No
Artificial Heart Valve	__ Yes	__ No	Frequent Diarrhea	__ Yes	__ No	Radiation Treatment	__ Yes	__ No
Artificial Joint	__ Yes	__ No	Frequent Headaches	__ Yes	__ No	Rheumatic Fever	__ Yes	__ No
Asthma	__ Yes	__ No	Genital Herpes	__ Yes	__ No	Shingles	__ Yes	__ No
Blood Disease	__ Yes	__ No	Glaucoma	__ Yes	__ No	Sickle Cell Disease	__ Yes	__ No
Blood Transfusion	__ Yes	__ No	Hay Fever	__ Yes	__ No	Sinus Trouble	__ Yes	__ No
Breathing Problems	__ Yes	__ No	Heart Attack/Failure	__ Yes	__ No	Spina Bifida	__ Yes	__ No
Bruise Easily	__ Yes	__ No	Heart Trouble/Disease	__ Yes	__ No	Stomach Disease	__ Yes	__ No
Cancer	__ Yes	__ No	Heart Murmur	__ Yes	__ No	Swelling of Limbs	__ Yes	__ No
Chemotherapy	__ Yes	__ No	Heart Pace Maker	__ Yes	__ No	Thyroid Disease	__ Yes	__ No
Chest Pains	__ Yes	__ No	Hemophilia	__ Yes	__ No	Tonsillitis	__ Yes	__ No
Cold Sores/Blister	__ Yes	__ No	Hepatitis A	__ Yes	__ No	Tuberculosis	__ Yes	__ No
Congenital Heart Disorder	__ Yes	__ No	Hepatitis B or C	__ Yes	__ No	Tumors or Growths	__ Yes	__ No
Convulsions	__ Yes	__ No	Herpes	__ Yes	__ No	Ulcers	__ Yes	__ No
Cortisone Medicine	__ Yes	__ No	High Blood Pressure	__ Yes	__ No	Venereal Disease	__ Yes	__ No
Diabetes	__ Yes	__ No	Hypoglycemia	__ Yes	__ No	Yellow Jaundice	__ Yes	__ No
Drug Addiction	__ Yes	__ No	Irregular Heartbeat	__ Yes	__ No	Other: ________________________________		
Easily Winded	__ Yes	__ No	Kidney Problems	__ Yes	__ No	____________________________________		

Do you have or have you had any disease, condition or problem not listed above? __ Yes __ No If yes, please explain ______________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

Signature of Patient or Guardian ____ Date ______________

DENTAL HISTORY

Please answer the following questions in regards to your current and previous dental history. Thank you!

Reason for your visit today? ______________________________

Date of last dental visit ______________ Last dental cleaning ______________ Last full mouth x-ray ______________

What was done at your last dental visit? ______________________________

Previous Dentist's Name: ______________________________ Telephone: ______________

Address: ______________________________ City/St/Zip: ______________________________

How often do you have dental cleanings and exams? ______________ How often do you brush your teeth? ______________

How often do you floss? __________ Other dental aids used? (water flosser, toothpick, etc.) ______________________

Do you have any dental problems now? Yes __ No __ If yes, please describe: ______________________________

Are any of your teeth sensitive to:

Hot or cold? Yes __ No __

Sweets? Yes __ No __

Biting / chewing? Yes __ No __

Have you noticed bad odor/taste? Yes __ No __

Do you get cold sores, blisters or other oral lesions? Yes __ No __

Do your gums bleed or hurt? Yes __ No __

Have your parents experienced gum disease / tooth loss? Yes __ No __

Have you noticed change in your bite? Yes __ No __

Does food tend to become caught in your teeth? Yes __ No __

If yes, where? ______________________

Do you:

Clench or grind your teeth? Yes __ No __

Bite your lip or cheeks? Yes __ No __

Hold foreign objects with your teeth? (pencils, nails, pipe) Yes __ No __

Mouth breathe while awake/asleep? Yes __ No __

Have a tired jaw in the morning? Yes __ No __

Snore or have any other sleeping disorders? Yes __ No __

Do you or have you used a CPAP? Yes __ No __

Smoke/chew tobacco or use any other tobacco product? Yes __ No __

Have you ever had:

Orthodontic treatment? Yes __ No __

Oral Surgery? Yes __ No __

Periodontal treatment? Yes __ No __

Your teeth ground or a bite adjustment? Yes __ No __

A bite plate/mouth guard? Yes __ No __

A serious injury to the mouth or head? Yes __ No __

If so, please explain: ______________________

____

Have you ever experienced:

Clicking or popping of the jaw? Yes __ No __

Pain? (joint, ear, side of face) Yes __ No __

Difficulty opening or closing of your mouth? Yes __ No __

Headaches, neck aches? Yes __ No __

Sore muscles (neck/shoulder)? Yes __ No __

Dental Anxiety? Yes __ No __

Are you satisfied with your teeth's appearance?

Please explain: ______________________

Have you had an upsetting dental experience?

Please explain: ______________________

____

Are there any other concerns about dental treatment you would like us to know? (Please comment)

____

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Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Full Name: ____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

> Contact Person: **Barney Family Dental**
> Telephone: **(503) 579-2812** Fax: **(503) 579-6435**
> E-mail: **info@barneydental.com**
> Address: 14780 SW Osprey Drive, Ste 200, Beaverton OR 97007

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing, this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: _______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information and treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: ____ Date: ________________________