

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____
SS#/Patient ID # _____
Patient Name _____

Address _____
City _____ State _____ Zip _____
How Long? _____ Rent Own
E-mail _____
Sex M F Age _____
Birth Date _____
Driver's License # _____
 Married Widowed Single Minor
 Separated Divorced Partnered For _____ Years
Occupation _____
Patient Employer/School _____
How long at this employer/school? _____
Employer/School Address _____
Employer/School Phone _____
Spouse's Name _____
Spouse's Birth Date _____
Spouse's SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is financially responsible for this account?

Relationship to Patient _____
Insurance Co. _____

Group# _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birth Date _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Insurance Assignment
I certify that I, and/or my dependents(s), have insurance coverage
with _____ and assign directly to
Name of insurance company(ies)
Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered.
Financial and Personal Health Information
I understand that I am financially responsible for all charges whether or
not paid by insurance. I authorize the use of my signature on all insurance
submissions. The above named dentist may use my health care informa-
tion and may disclose such information for treatment, payment and health
care operations. This consent will end when my current treatment plan is
completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____
Spouse's Work (_____) _____ Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

4 CREDIT REFERENCES

Name of Bank _____ Branch _____
Bank Cards (VISA/MC) _____ Gas Cards _____
_____ Store Account or Other _____

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DENTAL HISTORY

Reason for today's visit _____
 Former Dentist _____
 City/State _____
 Date of last dental visit _____
 Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- Bad Breath Yes No
- Bleeding Gums Yes No
- Blisters on lips or mouth Yes No
- Burning sensation on tongue Yes No
- Chew on one side of mouth Yes No
- Cigarette, pipe, or cigar smoking Yes No
- Clicking or popping jaw Yes No
- Dry Mouth Yes No
- Fingernail Biting Yes No
- Food collection between the teeth Yes No

- Foreign Objects Yes No
- Grinding Teeth Yes No
- Gums swollen or tender Yes No
- Jaw pain or tiredness Yes No
- Lip or cheek biting Yes No
- Loose teeth or broken fillings Yes No
- Mouth Breathing Yes No
- Mouth pain, brushing Yes No
- Orthodontic Treatment Yes No
- Pain around ear Yes No
- Periodontal Treatment Yes No
- Sensitivity to cold Yes No
- Sensitivity to heat Yes No
- Sensitivity to sweets Yes No
- Sensitivity when biting Yes No
- Sore or growths in your mouth Yes No
- How often do you floss? _____
- How often do you brush? _____

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HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | |
|--|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with
extractions or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on
head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, Persistent/Bloody <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss (unexplained) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

 Pharmacy Name _____
 Phone (____) _____

ALLERGIES

- Aspirin
- Barbiturates (Sleeping pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other _____

**TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES**

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	15.00%
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	If you are charged interest, the charge will be no less than \$1.00

FEES	
Late Charge	\$5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of \$20.00
Non-Sufficient Funds (NSF) Fee	\$25.00 per payment

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first \$50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Dental Entity Name

Signature

Date

Account Name

Address

A photocopy of this document may act as an original

Form 05304IL (7-1-17)