BARRETT
FAMILY DENTAL

1865 NW 169th Pl, Suite 120, Beaverton, OR 97006
503-690-9667 www.barrettfamilydental.com

Intake Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, and maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there maybe additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. Our office does not use this information to discriminate.

Patient Information

Date (mm/dd/yyyy)	**Date of Birth (mm/dd/yyyy)**	**Sex**	**Social Security Number**
Last Name	**First Name**	**MI**	
Address	**City**	**State**	**ZIP**
Mailing Address (if different)	**City**	**State**	**ZIP**
Home Phone	**Cell Phone**	**Work Phone**	**E-Mail Address**
Preferred Methods to Confirm Appointments (Circle): Phone Text E-mail			**Marital Status**
Occupation		**Employer**	
Emergency Contact	**Relationship**	**Home Phone**	**Cell Phone**

Responsible Party Information (if Patient is a Dependent)

Last Name	**First Name**	**MI**	
Address	**City**	**State**	**ZIP**
Relationship to Patient			
Home Phone	**Cell Phone**	**Work Phone**	**E-Mail Address**
Social Security Number	**Date of Birth (mm/dd/yyyy)**	**Employer**	

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Please Check the Following:	Yes	No
– Sensitivity (hot, cold, sweet) Where? UR UL LR LL	☐	☐
– Loose, tipped, or shifting teeth	☐	☐
– Mouth ulcers or cold sores	☐	☐
– Teeth or fillings breaking	☐	☐
– Grinding or clenching teeth	☐	☐
– Bleeding, swollen, or irritated gums	☐	☐
– Headaches, ear aches, neck aches, or jaw joint pain	☐	☐
– Bad Breath	☐	☐
– Snoring	☐	☐

Do you or have you had any of the following:

– Dentures	☐	☐
– Partial dentures	☐	☐
– Braces	☐	☐
– Gum treatments	☐	☐

Please share the following dates:

– Your last cleaning ___ /___
– Your last oral cancer screening ___ /___
– Your last complete dental X-rays ___ /___

Name of your previous dentist:

City: **State:**

Why did you leave your previous dentist?

	Yes	No
– Do you smoke, use chewing tobacco, or vape?	☐	☐

How much? _____ For how long? _____

If I could change my smile, I would:

– Make my teeth whiter	☐	☐
– Make my teeth straighter	☐	☐
– Close spaces	☐	☐
– Replace metal fillings with tooth colored restorations	☐	☐
– Repair chipped teeth	☐	☐
– Replace missing teeth	☐	☐
– Replace old crowns that don't match	☐	☐
– Have a smile makeover	☐	☐
– If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐

On a scale of 1-10, with 10 being the highest:

– How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

– Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

What is the most important thing about your dental visit today?

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Medical History

Patient Name	Date of Birth

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

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

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

Have you ever had any serious illness not listed	Yes No	If yes

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 the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian

Signature Date

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COVID-19 Screening Form

Do you/they have a fever or have you felt hot or feverish recently (in the last 14-21 days)?	Yes	No
Are you/they having shortness of breath or other difficulties breathing?	Yes	No
Do you/they have a cough?	Yes	No
Any other flu-like symptoms such as gastrointestinal upset, headache, or fatigue?	Yes	No
Are you/they experiencing recent loss of taste or smell?	Yes	No
Are you/they in contact with any confirmed COVID-19 positive patients?	Yes	No
Is your/their age over 60?	Yes	No
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any other auto-immune disorders?	Yes	No
Have you/they ever been diagnosed with COVID-19? If yes, please list date.	Yes Date: _____	No
Are you/they vaccinated for COVID-19?	Yes	No
If vaccinated for COVID-19, please indicate if you/they are Fully or Partially vaccinated.	Fully	Partially

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Patient Name

Dental Insurance Policy

Barrett Family Dental proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance practices. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by the patient. **All estimated co-payments are due at the time of service.**

Checks that are returned to our office by your financial institution are subject to a $50.00 returned check fee. This fee covers the processing fees that are charge to our office for a returned check.

The Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

PATIENT ACKNOWLEDGEMENT AND AUTHORIZATON

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Barrett Family Dental PC. This assignment will remain in effect unless revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature	Date

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Cancellation Policy

Barrett Family Dental makes an effort to see patients on time in order to give patients the care they deserve. Your scheduled appointment time is reserved for you. Therefore, we ask that you **please give us 48 hours notice if you are unable to keep your scheduled appointment.** Failure to provide 48 hours notice or not showing up for an appointment is considered a "failed appointment." **We reserve the right to charge a cancellation fee of $50.00 for a failed appointment. We also reserve the right to dismiss any patient who fails two or more appointments.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature Date

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*****You May Refuse to Sign This Acknowledgement*****

Acknowledgement of the Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices dated September 13, 2018.

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because

- Individual Refused to Sign
- Communication Barriers Prohibited Obtaining the Acknowledgement
- An Emergency Situation Prevented Us from Obtaining Acknowledgement
- Other (Please Specify):_____

Staff Member Name

Staff Member Signature

Signature Date