BARRETT
FAMILY DENTAL

15455 NW Greenbrier PKWY, Suite 235, 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

Patient Name (Last, First, MI)*			**Date of Birth***
Address*			
Social Security Number*		**Sex**	**Martial Status**
Home Phone	**Cell Phone***	**Work Phone**	**E-Mail**
Name of Responsible Party and Relationship to Patient (if Patient is a Dependent)*			
Emergency Contact (Name, Relationship, Phone Number)			
How Did You Hear About Us?			

Insurance Information*

Insured Person's Full Legal Name	**Date of Birth**	**Social Security Number**
Relationship to Patient	**Employer Name**	
Insurance Company	**Insurance Phone Number**	
Insurance Member ID Number	**Insurance Group Number**	
Insurance Mailing Address		

***Required Information**

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

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, drugs or herbal remedies? ◯ 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: _____

Do you use tobacco? ◯ Yes ◯ No _____

Do you use controlled substances? ◯ Yes ◯ No _____

For Women: Are you pregnant/trying to get pregnant? ◯ Yes ◯ No _____

For Women: Are you taking oral contraceptives? ◯ Yes ◯ No _____

For Women: Are you 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 the 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: _____

Are you or have you ever taken any bisphosphonate medication (Boniva, Actonel, Fosamax, Zometa, etc.)? ◯ Yes ◯ No

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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Patient Name

Financial 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 $100.00 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 of cancellation will result in a short notice cancellation charge. **The fee for short notice cancellation is $75.00 per hour cancelled.**

Barrett Family Dental utilizes an automated phone and texting service to provide appointment reminders. This system is not configured to allow for appointment changes. Any attempts to change appointments using the texting service or after-hours phones may not be received. If you must change your appointment, please call and speak with a member of the team during normal business hours.

I understand and agree.

Signature Date

Acknowledgement of the Receipt of Notice of Privacy Practices

The Notice of Privacy Practices describes how my private health information may be used and disclosed and how I can get access to this information.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature Date

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Authorization for Release of Information

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

In the State of Oregon, the medical age of consent is 15 years of age. This form is required for the release of information for any patient age 15 or older.

I authorize *Barrett Family Dental* to release my medical and/or billing, appointment, financial, and/or treatment information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above authorized recipient or voicemail or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email.

You have the right to revoke this consent in writing.

Signature:_____Date:_____