

**PATIENT REGISTRATION**

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Patient Is: ☐ Policy Holder☐ Responsible Party

Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

☐ Responsible Party is also a Policy Holder for Patient☐ Primary Insurance Policy Holder☐ Secondary Insurance Policy Holder

## Patient Information

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State / Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Sex: ☐ Male☐ FemaleMarital Status: ☐ Married☐ Single☐ Divorced☐ Separated☐ Widowed

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_

☐ I would like to receive correspondences via e-mail.

## Section 2

## Section 3

Employment Status: ☐ Full Time☐ Part Time☐ RetiredStudent Status: ☐ Full Time☐ Part Time

Medicaid ID: \_\_\_\_\_

Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_

Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_

Pref. Hyg: \_\_\_\_\_

Emer Contact Phone \_\_\_\_\_

Contact Relationship \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Referred By \_\_\_\_\_

Spouse Name \_\_\_\_\_

## Primary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured: ☐ Self☐ Spouse☐ Child☐ Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_

## Secondary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured: ☐ Self☐ Spouse☐ Child☐ Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_

## Chinook Falls Dental Clinic PC Medical History(Current 7-14)

Patient Name:

Birth Date:

Date Created:

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 interaction with the dental care you will receive. Thank you for answering the following:

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you pregnant, trying to get pregnant or think you may be pregnant?	<input type="radio"/> Yes <input type="radio"/> No		
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you use medical marijuana or any controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking a blood thinner? (e.g., Warfarin, Coumadin, etc?)	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
If yes, do you know your INR?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any prescription or non prescription medication, including vitamins?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Medications continued:

Do you use tobacco or nicotine products?

Cigarettes	<input type="radio"/> Yes <input type="radio"/> No	E-Cigarettes	<input type="radio"/> Yes <input type="radio"/> No	Chewing Tobacco	<input type="radio"/> Yes <input type="radio"/> No	Cigars or Pipes	<input type="radio"/> Yes <input type="radio"/> No
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Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics

Other Allergy?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
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Have you been diagnosed with Diabetes?	<input type="radio"/> Yes <input type="radio"/> No		
If yes, do you know your most recent A1C/eAG #	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Preprandial	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Postprandial	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Do you have an artificial joint?

Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Has doctor recommended pre-medication?	<input type="radio"/> Yes <input type="radio"/> No
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Have you been diagnosed with cancer?

Cancer	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No
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Have you been diagnosed with Heart problems, or have you had any of the following?

Angina	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No
High/Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Bacterial Endocarditis	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No

Have you been diagnosed with Lung complications?

Asthma	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
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Have you been diagnosed with Liver complications?

Cirrhosis	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No
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Have you been diagnosed with a neurological disorder?

Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's Disease	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
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Have you experienced any of the following conditions?

Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No
Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever been diagnosed with, or experienced, any of the following?

AIDS/HIV positive	<input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Blood Clots	<input type="radio"/> Yes <input type="radio"/> No	GERD	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Herpes/HSV-2	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Organ Transplant	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Peripheral Neuropathy	<input type="radio"/> Yes <input type="radio"/> No
Shingles	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease/STDs	<input type="radio"/> Yes <input type="radio"/> No				

Have you had any serious illness not listed above?

☐ Yes ☐ No

If yes

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:

X

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



# Chinook Falls Dental

## AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Authorized Individual: \_\_\_\_\_

Relationship: \_\_\_\_\_

### SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**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 to the individual above.

**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: Thao Le

Telephone: 503-668-8301

Address: 36840 SE Industrial Way, Sandy, OR 97055

**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 to 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: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**  
Include completed Consent in the patient's chart.



# Chinook Falls Dental

36840 Industrial Way, Suite A, Sandy, OR 97055  
503-668-8301

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature (or Parent/Guardian if minor)

\_\_\_\_\_  
Date

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)



# Chinook Falls Dental

36840 Industrial Way, Suite A, Sandy, OR 97055  
503-668-8301

## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional

judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (**You must make your request in writing.**) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Thao Le

Telephone: 503-668-8301

Address: 36840 SE Industrial Way, Sandy, OR 97055





# Chinook Falls Dental

36840 Industrial Way, Suite A, Sandy, OR 97055  
503-668-8301

## Failure to Keep Appointment Policy ("No Show")

We are happy to do all we can to help patients make it to their appointments. We will try to confirm appointments two business days before the scheduled appointment.

Despite our best efforts to assist patients, "No Shows" still occur. This is lost time for our office. Other patients are waiting for appointments. Therefore, please be aware that there is a \$50 charge for "No Show" appointments. This will be billed directly to you and will **not** be covered by insurance. Signing this form indicates that you understand the reason for the charge and that payment is your responsibility. We require two business days notice to cancel your appointment to avoid this charge.

Frequent failure to keep scheduled appointments confirms to us that the patient - office relationship is not working. After multiple such events, we may send a letter to transfer the patient out of the practice. That letter is a 30-day written notice during which time we will see the patient for **emergency care** only.

Being fifteen (15) minutes or more late without phoning the office is considered a "No Show."

This is to acknowledge that I have been made aware of the Failure to Keep Appointment Policy (aka: Cancellation Policy) for Chinook Falls Dental.

Print Patient Name: X \_\_\_\_\_

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Responsible Party)



# Chinook Falls Dental

36840 Industrial Way, Suite A, Sandy, OR 97055  
503-668-8301

## FINANCIAL POLICIES and ARRANGEMENTS

As a courtesy, we will assist you by billing your dental insurance carrier for you. Please understand that we are not participating or in-network with all dental plans, but we will do our best to help you interpret your plan benefits. ***Also, please be aware that your co-insurance and/or patient responsibility portion is due at time of service.***

If you have no insurance, we require payment in full at time of service. We offer a 10% discount if you pay in full at the time of service with CASH, PERSONAL CHECK, or MONEY ORDER.

If you prefer to make payments, we also accept VISA, MASTERCARD, and other standard credit cards. (Please inquire.) Interest-free or extended payment plans are available through CareCredit (credit extended by Synchrony Bank, subject to credit approval).

Finance charges of 1.5% per month will be applied to any balance unpaid after 90 days.  
Minimum charge \$2.50    Annual percentage rate 18%

## OHP Disclaimer

It is our office policy as a standard of practice to accept the Oregon Health Plan ***only*** for those individuals 12 years of age or younger who are grandfathered into our practice. If you have OHP and still choose to obtain services here, you agree to be responsible for paying our standard fees for services.

## AUTHORIZATION and RELEASE

I authorize the clinic to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care, to insurance companies *and/or healthcare practitioners.*

I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and that of my dependents.

X \_\_\_\_\_  
Print Patient Name

X \_\_\_\_\_  
Signature of Patient (or parent/guardian, if minor)

X \_\_\_\_\_  
Date

*Thanks so much for choosing our office!*