WELCOME TO SMILES4OREGON · WE'RE SO GLAD TO SEE YOUR SMILE.

your information

LAST NAME _____ FIRST NAME _____

PREFERRED NAME _____ BIRTH DATE _____

CELL PHONE _____ WORK PHONE _____

OTHER PHONE _____ EMAIL ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMERGENCY NAME _____ EMERGENCY PHONE _____

How would you like us to stay in contact with you? ☐ VOICEMAIL ☐ TEXT ☐ EMAIL ☐ MAIL ☐ OTHER _____

How did you hear about us? _____

PLEASE REVIEW THE FOLLOWING IMPORTANT INFORMATION:

Please review the following and let us know if you have any questions or require any clarification. Once you have read and fully understand all points, please sign below:

- I hereby authorize Dr. John K. Sullivan or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Sullivan to make thorough diagnosis of my dental needs.
- Upon such diagnosis, I authorize Dr. Sullivan to provide 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 and other medication as necessary. I fully understand that using these agents embodies certain risks. I understand that I can request a list of possible complications.
- I have had full opportunity to read and consider the contents of the Smiles4Oregon Notice of Privacy Practices. I understand that I am giving my permission to Smiles4Oregon to use and disclose my protected health information where necessary in order to carry out treatment, payment activities and health care operations. I also understand that I have the right to revoke my permission at any time.
- I authorize doctor Sullivan, or designated staff, to use and disclose any oral situations or health records that are individually identifiable as mine for the purpose of my treatment, payment, and health care operations. I understand that the minimum amount of information necessary to provide quality health care will be used or disclosed and a notice fully outlining my personal health information is available.
- For my convenience this office may release my information to my insurance company and in turn will receive payment directly from them.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible
- Treatment plans may change and I will be responsible for the work actually done. Any changes from agreed upon financial arrangements will be discussed before treatment is rendered.
- I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service, unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account.
- I understand all of my health and dental history information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Smiles4Oregon and John K. Sullivan, DDS, has my permission to follow up with the appropriate parties. I will notify the doctor of any change in my health or medication.

THANK YOU!

PRINT PATIENT NAME _____ DATE _____

AUTHORIZED SIGNATURE _____

NAME | DATE | dental history

WE LOOK FORWARD TO GETTING TO KNOW YOUR SMILE.

What is the reason for your visit to Smiles4Oregon today? _____

When was your last dental visit? _____ Your last dental cleaning? _____ Last full mouth x-rays? _____

What was done at your last dental visit? _____

What is the name of your previous dentist? _____

Previous dentist's phone number? _____

How often do you have dental exams? _____ Brush your teeth? _____ Floss your teeth? _____

Have you ever used or are you currently using topical fluoride? _____

What other dental aids do you use? (interplak, toothpick, etc.) _____

Do you have any dental problems? ☐ YES ☐ NO *If yes, please tell us more:* _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING:

sweet or hot/cold sensitivity	☐ YES	☐ NO
biting or chewing sensitivity	☐ YES	☐ NO
mouth odors or a bad taste	☐ YES	☐ NO
cold sores, blisters or other oral lesions	☐ YES	☐ NO
gums that bleed or hurt	☐ YES	☐ NO
parents experienced gum disease or tooth loss	☐ YES	☐ NO
food getting caught in teeth	☐ YES	☐ NO

if yes, please tell us where: _____

PLEASE TELL US WHETHER YOU'VE EVER HAD:

orthodontic treatment	☐ YES	☐ NO
oral surgery	☐ YES	☐ NO
periodontal treatment	☐ YES	☐ NO
your bite adjusted or teeth ground	☐ YES	☐ NO
a bite plate or mouth guard	☐ YES	☐ NO
snoring, waking at night or exhausted	☐ YES	☐ NO
a serious injury to your mouth or head	☐ YES	☐ NO

if yes, please tell us about it: _____

HAVE YOU EVER FOUND YOURSELF EXPERIENCING:

clicking or popping of your jaw	☐ YES	☐ NO
pain in your joint, ear, side of face	☐ YES	☐ NO
difficulty opening and/or closing your mouth	☐ YES	☐ NO
difficulty chewing on either side of your mouth	☐ YES	☐ NO
chronic headaches, neckaches or shoulder aches	☐ YES	☐ NO
sore muscles in your temples, shoulders, neck, etc.	☐ YES	☐ NO

DO YOU EVER FIND YOURSELF DOING THE FOLLOWING:

clench or grind your teeth, while awake or asleep	☐ YES	☐ NO
regularly bite your lips and/or cheeks	☐ YES	☐ NO
hold foreign objects with your teeth: pencils, pipe, etc	☐ YES	☐ NO
breathe through your mouth while asleep or awake	☐ YES	☐ NO
experience tired jaws, especially in the morning	☐ YES	☐ NO
snoring, frequently waking at night, or waking exhausted	☐ YES	☐ NO
experiencing sleep apnea or other sleep problems	☐ YES	☐ NO

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? ☐ YES ☐ NO

if not or you're not sure, please tell us more: _____

Would you like to replace any silver fillings?	☐ YES	☐ NO
Would you like to keep all of your teeth all of your life?	☐ YES	☐ NO

VISITING THE TEAM AT SMILES4OREGON:

Studies show that at least 50% of American's experience anxiety when visiting the dentist, so if you find yourself among that number we want to help you in any way we can.

Do you feel nervous about dental treatment?	☐ YES	☐ NO
Have you ever had an upsetting dental experience?	☐ YES	☐ NO

If you have some anxiety, please tell us about it: _____

Have you ever been prescribed pre-medication before undergoing any dental treatment? ☐ YES ☐ NO

Please let us know anything else that you would like us to know so that we may serve you better: _____

NAME | DATE | medical history

LET US HELP KEEP YOU HEALTHY AND SMILING FOR LIFE.

Please let us know your current physician's information: _____
PHYSICIAN NAME

_____
PHYSICIAN PHONE

Have you had any medical care within the past two years? ☐ YES ☐ NO
if yes, please tell us about it: _____

Have you taken any medication or drugs during the past two years? ☐ YES ☐ NO
if yes, please list name(s) and dosage(s): _____

Are you currently taking any medication(s), including pills, drugs, herbals, regular aspirin and/or vitamins? ☐ YES ☐ NO
if yes, please list name(s) and dosage(s): _____

Have you taken the bone loss drug(s) Fosamax, Actonel, Boniva, or any other biophosphonates? ☐ YES ☐ NO

Have you been a patient in a hospital at any time in the past five years? ☐ YES ☐ NO
if yes, please tell us more: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

heart problems	☐ YES	☐ NO	special diet	☐ YES	☐ NO	emphysema	☐ YES	☐ NO
chest pain	☐ YES	☐ NO	diabetes type 1	☐ YES	☐ NO	allergies, hay fever, hives, etc.	☐ YES	☐ NO
congenital heart disease	☐ YES	☐ NO	diabetes type 2	☐ YES	☐ NO	any medication allergy	☐ YES	☐ NO
heart murmur	☐ YES	☐ NO	thyroid problems	☐ YES	☐ NO	sinus trouble	☐ YES	☐ NO
high or low blood pressure	☐ YES	☐ NO	cold sores/fever blisters	☐ YES	☐ NO	latex sensitivity	☐ YES	☐ NO
mitral valve prolapse	☐ YES	☐ NO	sexually transmitted disease(s)	☐ YES	☐ NO	tumors	☐ YES	☐ NO
artificial heart valve or pacemaker	☐ YES	☐ NO	AIDs/HIV positive	☐ YES	☐ NO	cancer	☐ YES	☐ NO
rheumatic fever	☐ YES	☐ NO	hepatitis A, B, or C	☐ YES	☐ NO	chemotherapy	☐ YES	☐ NO
arthritis or rheumatism	☐ YES	☐ NO	blood transfusion	☐ YES	☐ NO	radiation therapy	☐ YES	☐ NO
cortisone medicine	☐ YES	☐ NO	liver disease/jaundice	☐ YES	☐ NO	epilepsy or seizures	☐ YES	☐ NO
swollen ankles	☐ YES	☐ NO	bruise easily	☐ YES	☐ NO	neurological disorder	☐ YES	☐ NO
stroke	☐ YES	☐ NO	sickle cell anemia	☐ YES	☐ NO	fainting or dizzy spells	☐ YES	☐ NO
ulcers	☐ YES	☐ NO	hemophilia	☐ YES	☐ NO	anxiety	☐ YES	☐ NO
kidney trouble	☐ YES	☐ NO	tuberculosis	☐ YES	☐ NO	depression	☐ YES	☐ NO
glaucoma	☐ YES	☐ NO	asthma	☐ YES	☐ NO	under the care of a mental health professional	☐ YES	☐ NO
contact lenses/glasses	☐ YES	☐ NO	chronic cough	☐ YES	☐ NO	For women, are you currently pregnant?	☐ YES	☐ NO
joint replacement	☐ YES	☐ NO	tobacco/marijuana use	☐ YES	☐ NO	*if yes, what is your estimated due date:*	_____	

IS THERE ANYTHING ELSE WE SHOULD KNOW IN ORDER TO BETTER SERVE YOU?

_____

_____

_____

CONSENT FOR TREATMENT AT SMILES4OREGON

I hereby authorize John Sullivan, DDS or his designated staff to take x-rays, study models, photographs, and/or other diagnostic aids deemed appropriate by Dr. Sullivan in order to provide a thorough diagnosis of my dental health and needs.

Upon such diagnosis, I authorize Dr. John Sullivan to provide 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 and other medication as necessary and as agreed upon. I fully understand that using these agents embodies certain risks. I understand that I can request a list of possible complications.

I authorize Dr. Sullivan and/or his designated staff at Smiles4Oregon to use and disclose any oral situations or health records that are individually identifiable as mine for the purpose of my treatment, payment, and/or health care operations. I understand that the minimum amount of information necessary to provide quality health care will be used or disclosed by Smiles4Oregon, and that a HIPAA policy and procedure notice fully outlining my personal health information is available for my review at any time.

Should I have a dental insurance benefit plan available to me and/or my dependents, for my convenience the Smiles4Oregon dental office may release my information to my dental insurance company and in turn will receive payment directly from them. Every effort will be made to help me with maximize my dental insurance benefits. If they do not pay as expected, I understand that I will remain responsible for the balance.

I understand that dental treatment plans may sometimes change. Should such a change become necessary, I understand that Dr. Sullivan and Smiles4Oregon will inform me fully before proceeding and that I will be responsible for any and all dental treatment that is actually provided. Any changes from our original, mutually agreed upon financial arrangements will also be discussed and agreed upon before updated treatment is rendered.

I agree to be responsible for payment of all services rendered on my behalf as well as that of my dependents. I understand that payment is due at the time service is rendered unless other arrangements have been made in advance. In the event payments are not received as agreed I understand that a 1.5% late charge (18% APR) may be added to my account.

PATIENT NAME (PRINTED)

PATIENT SIGNATURE DATE