Today's Date: _______________ Patient Account #: _________________

Patient Information

Patient Name: ____ Nickname: ______________________
Last Name First Name Middle

Mailing Address: ____
Street City State Zip

Home Address (If Different): ____
Street City State Zip

Patient Birthdate: _______________ Social Security # (If patient is over 18yrs old) : ____________________________ Sex: M ☐ F ☐

Primary Phone #: ___________________ Home ☐ Cell ☐ Work ☐ Secondary Phone #: ___________________ Home ☐ Cell ☐ Work ☐

Email Address: ______________________________ How would you prefer to receive appointment confirmations? Phone ☐ Text ☐ Email ☐

How did you hear about our office? ____

Responsible Party/Guardian Information

*If this information is the same as above you may skip the next 4 lines and continue at the Employer information section.

Name: ____ Birthdate: ________________
Last Name First Name Middle

Social Security #: ______________________________________ Relationship to Patient: ______________________

Mailing Address: ____
Street City State Zip

Primary Phone #: ____________________Home ☐ Cell ☐ Work ☐ Secondary Phone #: ___________________Home ☐ Cell ☐ Work ☐

*Employer: ___________________________________ Occupation: _____________________ # Years Employed: _________

Spouse Name: ____ Birthdate: ______________ SS #: ___________________
Last First Middle

Spouse Primary Phone #: _______________ HM ☐ Cell ☐ WRK ☐ Spouse Secondary Phone #: ______________ HM ☐ Cell ☐ WRK ☐

Spouse Employer: ____________________________ Occupation: ______________________ # Years Employed: _________

Dental Insurance Information

Subscriber Name: ____ Subscriber ID or SS #: _________________________

Subscriber DOB: ______________Insurance Co. Name: ________________________ Insur Phone #: _____________________

Subscriber Employer: ____ Group #: ___________

Do you have dual coverage? Yes ☐ No ☐ If yes:

Subscriber Name: ______________________________ ID or SS #: _____________________ Subscriber DOB: _____________

Insur Co. Name: ____________________ Insur Phone #: __________________ Employer: _________________ Grp #: _______

Emergency Contact Information

Name: ____________________________________ Phone #: __________________________ Relationship: ______________

Name: ____________________________________ Phone #: __________________________ Relationship: ______________

Medical Health

What would you consider your general health to be? Excellent ☐ Good ☐ Fair ☐ Poor ☐
Primary Care Physician Name: ____ Physician Phone #: _____________________
When was your last complete physical/check-up? ____

Are you taking any medication? Yes ☐ No ☐
Medication: ____ For what purpose? ___________________________
Medication: ____ For what purpose? ___________________________
Medication: ____ For what purpose? ___________________________
Medication: ____ For what purpose? ___________________________
Medication: ____ For what purpose? ___________________________

Do you have or have you ever had:

Condition	Yes	No	Condition	Yes	No
Heart Disease	Yes ☐	No ☐	Tuberculosis or Lung Disease	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐
Abnormal Blood Pressure	Yes ☐	No ☐	Asthma or Hay Fever	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sinus Trouble	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Epilepsy/Seizures	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Congenital Heart Lesions	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Frequent Headaches	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐
HIV-positive	Yes ☐	No ☐	AIDS	Yes ☐	No ☐
Cancer/Radiation Treatment	Yes ☐	No ☐	Joint Replacements	Yes ☐	No ☐
Angina (Chest Pain)	Yes ☐	No ☐	Dry Mouth	Yes ☐	No ☐
Tumors	Yes ☐	No ☐	Dementia/Alzheimer's Disease	Yes ☐	No ☐
Substance Abuse Problems	Yes ☐	No ☐	Organ Transplant	Yes ☐	No ☐
Mental Illness	Yes ☐	No ☐			

Are you allergic to: Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Local Injected Anesthetics ☐ Iodine ☐ Metals/Nickel ☐
Aspirin ☐ Ibuprofen ☐ Latex or Plastics ☐ Any Other Medications/Materials? ________________________

Do you take antibiotics prior to dental treatment? Yes ☐ No ☐
Do you use tobacco products? Yes ☐ No ☐
Are you subject to prolonged bleeding? Yes ☐ No ☐
Are you taking any blood thinners? Yes ☐ No ☐
Do you have excessive urination and/or thirst? Yes ☐ No ☐
Are you subject to fainting spells? Yes ☐ No ☐
Have you had any major surgeries? Year: ______ Type of Surgery: _______________ Year: _______ Type of Surgery: ______________
Do you have any other medical problems not listed? Yes ☐ No ☐ If yes explain: ____
Women: Are you or could you be pregnant? Yes ☐ No ☐ If yes, Due Date? ___________________ Are you nursing? Yes ☐ No ☐

Dental Health

Reason for your visit today: _____________________________________ When was your last dental visit? _______________________
Have you ever had any serious problem associated with previous dental treatment? Yes ☐ No ☐
Explain: ____
Are you experiencing any tooth, mouth, or jaw pain? Yes ☐ No ☐ Explain: ____
Do you avoid brushing any part of your mouth because of pain? Yes ☐ No ☐ Explain: ____________________________________
How often do you brush your teeth? ________________________ How often do you floss? ___________________________________
What type/texture toothbrush to you use? Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Natural ☐
Do your gums bleed when brushing? Yes ☐ No ☐
Do your gums bleed when flossing? Yes ☐ No ☐
Do you use an electric toothbrush and/or WaterPik? Yes ☐ No ☐
Overall, are you satisfied with the appearance of your teeth? Yes ☐ No ☐
Would you like to talk with us about making your teeth straighter? Yes ☐ No ☐
Would you like your teeth to be whiter? Yes ☐ No ☐

OFFICE USE: Periodic Medical/Dental Health Review
Date: ____________ Changes to health: ________________________________ New Medications________________________ Staff Initials ______
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NOTICE OF PRIVACY PRACTICES

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.

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 (01/01/2009), 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.

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, text messages, emails, postcards, or letters).

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 may 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.

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.

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: Dr. James V. Frohnmayer

Telephone: 503-289-7043 Fax: 503-289-1425

E-mail: smile@portsmouthdentalcare.us

Address: 5228 N Lombard St. Portland, OR 97203

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Portsmouth Dental Care

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.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

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)

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