

St. Helens Dental Center
Michael Van Gordon, D.M.D.
36200 Pittsburg Rd. St. Helens, OR 97051 (503)397-1315

Date _____

First Name: _____ Last Name: _____ Middle Initial: _____
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 Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____
E-mail: _____

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time

Additional Comments:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: 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: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: 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: _____

MEDICAL HISTORY

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, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? 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
- Local Anesthetics

Other If yes, please explain: _____

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

- | | | | | |
|------------------------|---------------------------|-----------------------|-----------------------|----------------------------|
| AIDS/HIV Positive | Chest Pains | Frequent Headaches | Irregular Heartbeat | Scarlet Fever |
| Alzheimer's Disease | Cold Sores/Fever Blisters | Genital Herpes | Kidney Problems | Shingles |
| Anaphylaxis | Congenital Heart Disorder | Glaucoma | Leukemia | Sickle Cell Disease |
| Anemia | Convulsions | Hay Fever | Liver Disease | Sinus Trouble |
| Angina | Cortisone Medicine | Heart Attack/Failure | Low Blood Pressure | Spina Bifida |
| Arthritis/Gout | Diabetes | Heart Murmur | Lung Disease | Stomach/Intestinal Disease |
| Artificial Heart Valve | Drug Addiction | Heart Pace Maker | Mitral Valve Prolapse | Stroke |
| Artificial Joint | Easily Winded | Heart Trouble/Disease | Pain in Jaw Joints | Swelling of Limbs |
| Asthma | Emphysema | Hemophilia | Parathyroid Disease | Thyroid Disease |
| Blood Disease | Epilepsy or Seizures | Hepatitis A | Psychiatric Care | Tonsillitis |
| Blood Transfusion | Excessive Bleeding | Hepatitis B or C | Radiation Treatments | Tuberculosis |
| Breathing Problem | Excessive Thirst | Herpes | Recent Weight Loss | Tumors or Growths |
| Bruise Easily | Fainting Spells/Dizziness | High Blood Pressure | Renal Dialysis | Ulcers |
| Cancer | Frequent Cough | Hives or Rash | Rheumatic Fever | Venereal Disease |
| Chemotherapy | Frequent Diarrhea | Hypoglycemia | Rheumatism | Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____ DATE _____

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Financial Agreement

Patient name _____

Thank you for choosing our office for your dental care. As a condition of your dental treatment by this office, financial arrangements must be made in advance. Our practice depends upon reimbursement from our patients for the costs incurred during your care. Financial responsibility on the part of each patient must be determined before treatment. Payment for service is due at the time services are rendered. We accept the following methods of payment: Cash, Check, Visa, Master Card, American Express, Discover and CareCredit.

As a courtesy to our patients with dental insurance, we are happy to file a claim on your behalf, but you are ultimately responsible for all dates of service. Please understand your insurance is a contract between you & your insurance company. We simply bill your insurance as a courtesy to you. Not all services are covered benefits by some insurance companies. Patients with dental insurance must provide complete coverage information in order to submit claims to your insurance. During your first visit, we will try to contact your insurance to verify coverage. You will be responsible for any co-pay or deductible at each visit.

If after 60 days your insurance has not paid its portion, you will be sent a statement for payment. Accounts over 60 days are assessed a finance charge of 18.5% APR. After 120 days, patients not responding to statements and letters of overdue accounts will be turned over for collection. This may lead to additional legal fees being added to your balance.

We require a \$75 account deposit per family at the first appointment to begin to cover any charges that may not be covered by your insurance. If a credit remains on the account after all ins. is paid, that amount will be refunded to you.

A FEE OF \$50 WILL BE CHARGED FOR ALL MISSED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE.

I have read and understand the information on this form and agree that regardless of my insurance status, I am responsible for the balance on my account for all services.

Signature: _____ Date: _____



**St. Helens
Dental Center**

Michael Van Gordon, D.M.D.
GENERAL DENTISTRY

36200 Pittsburg Rd.
St. Helens, OR 97051
(503) 397-1315
smile@oregonvos.net

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.

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)

