Phillippe C. Freeman, DMD, FAGD

DESCHUTES DENTAL CENTER

Our Mission: It is the goal of our practice to provide you, our patients with unequalled excellence, from state-of-the-art materials and techniques to personal responsiveness to your needs. Our education and skill are continually updated with the purpose and desire to enhance the lives of you and your family. We have dedicated ourselves to providing you with healthy, beautiful smiles using therapies we would be proud to perform for our own families.

Patient Name: _____ Today's Date: _____

Date of Birth: _____ SS#: _____ Email: _____

Preferred Phone: _____ Who Can We Thank for Referring you to Our Office?: _____

Home Address: _____ Zip/State: _____

Occupation: _____ Employer: _____

Person Responsible for Account: _____ Marital Status: _____

Spouse's Name: _____ Date of Birth: _____ Spouse SS#: _____

Spouse's Occupation: _____ Employer: _____

Last Dental Treatment: _____ Former Dentist: _____

Your Physician: _____ Phone: _____ Last Visit: _____

DENTAL QUESTIONAIRE:

SMILE EVALUATION:

Check One:

☐ Yes ☐ No Do you like the color of your teeth? If not, explain: _____

☐ Yes ☐ No Are you nervous about seeing the dentist? If yes please tell us why: _____

☐ Yes ☐ No My gums bleed when I floss.

☐ Yes ☐ No My gums feel tender or swollen.

☐ Yes ☐ No I avoid brushing part of my mouth due to pain.

☐ Yes ☐ No I have problems eating.

1. What are your dental priorities? (appearance, good health, comfort, financial considerations, longevity, etc.)

_____

2. What is most important to you regarding the dentistry provided for you? _____

_____

3. If you could change anything in the appearance of your smile, what would you most like to improve, and how would you like your teeth to look? _____

4. Why have you come to see us today? (pain, check up, cosmetic concerns, etc.) _____

_____

Signature of Patient, Parent, or Guardian _____ **Date** _____

DESCHUTES
DENTAL CENTER

Name: _____ **Date** _____

PLEASE PROVIDE COPY OF YOUR INSURANCE CARD OR FILL OUT SECTION BELOW

PRIMARY INSURANCE

Insurance Co: _____
ID #: _____
Group #: _____
Ins. Co. Address: _____
_____
Phone #: _____
Name of insured: _____
Relationship to patient: _____
DOB of insured: _____
Employer: _____

SECONDARY INSURANCE

Insurance Co: _____
ID #: _____
Group #: _____
Ins. Co. Address: _____
_____
Phone #: _____
Name of insured: _____
Relationship to patient: _____
DOB of insured: _____
Employer: _____

After initial radiographs and examination, we will provide you with an estimate of fees to cover treatment. All estimates are based upon conditions as viewed at the time of diagnosis; unforeseen circumstances could alter an estimated fee. As all dental insurance policies vary in benefits, you can estimate that your policy probably covers between 40%-80% of your routine dental treatment. As a courtesy to you we will submit the forms for your benefits. Payment of the remaining balance is your responsibility.

Please indicate below your preferred payment arrangement:

1. ☐ Payment the day of each appointment. 5% discount with full payment by cash or check the day of service.
2. ☐ Payment by Bank Card (we accept Visa, MasterCard, Discover, American Express and Debit Cards).
3. ☐ Financing through a dental financial plan (such as Care Credit)

*** Crowns, bridges and removable prosthesis restorations require a minimum payment of 50% by the first appointment.**
*** Cosmetic services such as teeth whitening, veneers, smile makeovers, implants or other elective cosmetic enhancements require payment in full at time of treatment, if not otherwise covered by insurance benefits.**

There will be a finance charge of 1.6% per month on all accounts over 60 days.

We appreciate the opportunity to serve you. We will gladly discuss and answer any questions you may have regarding your needed dental care or your financing options.

***Authorization for release of health information:** I authorize the health care provider to release to my insurance company any information including x-rays, that may be needed to evaluate a claim for benefits.*

Signature of Patient, Parent, or Guardian _____ Date _____

DESCHUTES DENTAL CENTER

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.

Name: _____ **Date** _____

Medical History:

********If your answer is yes to any of the following please explain********

1. Are you under a physicians care now? ☐ Yes ☐ No _____
2. Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____
3. Have you ever had a serious head or neck injury? ☐ Yes ☐ No _____
4. Are you taking any medications, pills, or drugs? ☐ Yes ☐ No **If yes please fill out back of this form.**
5. Do you take vitamins or herbal supplements? ☐ Yes ☐ No **If yes please fill out back of this form.**
6. Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No _____
7. Have you ever taken Fosamax, Boniva, Atonel, or any other medications containing biphosphonates? ☐ Yes ☐ No _____
8. Are you on a special diet? ☐ Yes ☐ No _____
9. Do you us any tobacco products? ☐ Yes ☐ No _____
10. Do you use any controlled substances? ☐ Yes ☐ No _____

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other If yes, Please Explain: _____

WOMEN: ***Are you:***

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

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

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

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing false 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 _____

In case of an emergency please contact _____ Phone _____

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