KEILMAN DENTAL CLINIC, PC

DENTAL HEALTH HISTORY

Please check your answer to the following	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Has your jaw ever locked during treatment?	☐	☐
Have you ever had complications with dental anesthetic?	☐	☐
Do you wear dentures or partials?	☐	☐
When were they made? _____		
Do you have any other kind of dental appliance that you wear?	☐	☐
What kind? _____		
Do you have any dental implants?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐
How often do you brush? _____		
How often do you floss? _____		
Do you use fluoride supplements? (toothpaste, mouth rinses)	☐	☐
Have you noticed slow-healing sores in or around your mouth?	☐	☐
Do you use tobacco products such as cigarettes or chewing tobacco?	☐	☐
How long have you used? _____		
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Citric foods or liquids (lemons)?	☐	☐
Sweet foods or liquids?	☐	☐
Does your jaw make noise that bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Does it hurt when you chew or open wide to take a bite of food?	☐	☐
Does your jaw ever get stuck so that you can't open freely?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
When you wake up, do you have jaw pain or headaches?	☐	☐
Have you had a blow to the jaw (trauma) or history of dental trauma in general?	☐	☐
Do you suffer from dry mouth?	☐	☐
Do you prefer to save your teeth?	☐	☐

If there was anything you could change about your smile what would it be?

_____

_____

_____

Reviewed by _____Date _____

KEILMAN DENTAL CLINIC, PC

Financial Policy

In the interest of good healthcare practice, it is desirable to establish a Financial Policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

PAYMENT IN FULL
Full payment is required at the time of service from all patients that do not have insurance coverage.

PAYMENT OPTIONS CASH OR CHECK
We are happy to offer a 5% courtesy adjustment for all treatment paid with cash or check. This is a bookkeeping fee discount, therefore cannot be given to clients paying with Credit Card or have insurance. Any RETURNED CHECKS for insufficient funds will be subject to a $30.00 service fee.

- **CREDIT CARDS:** Our office can accept American Express, Discover, Master Card, Visa, Debit Cards, HSA account cards for payment.
- **Supplement financing:** For patients who desire a monthly payment plan, we have made arrangements with a finance company. There are no application fees or down payment and the loan can be interest-free. Applications are available from our office and approval is provided quickly.
- ***If your account develops a credit balance**, it will be audited to determine if the credit is due to the insurance or the client. Audits on credit accounts are done on a monthly basis. If the amount of the credit is less than $10.00 you agree that the clinic will keep the credit on the account for future treatment.*

PAST DUE BALANCES
A past due balance is any amount owed from a prior visit where insurance is not pending or an insurance payment has not been received within 60 days. All unpaid balances are subject to a 1.5% monthly service charge. Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time of service. Severely delinquent accounts will be assigned to a collection agency.

Third Party Claims
Payment in full is expected for services rendered at the time of your visit. We do not wait for payment while settlements are being reached even if it involves an attorney.

DENTAL INSURANCE
Our office staff understands insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract. *It is important that you realize however:*

- Your unpaid deductible and any estimated portion of fees not covered by your insurance are due at the time of service.
- We cannot guarantee any estimated coverage.
- Your insurance benefit is a contract between you, your employer (if applicable), and the insurance company.
- This office files your insurance claim as a courtesy to you. We will bill your PRIMARY and SECONDARY insurance plans as long as they are provided at the time treatment begins.
- Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your insurance company.
- Not all services are a covered benefit in all contracts.
- You (not the insurance company) are responsible to us for all fees for services rendered to you.
- Upon request, a pre-determined estimate of benefits can be given to you, but this too is not a guarantee of payment from your insurance.
- Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account.

I have read this office and credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

As legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office, as stated above

_____ _____

Signature of Patient or Responsible Party Date

Signed copy given to responsible party_____ Copy Declined_____

Keilman Dental Clinic, PC
421 W 9th Street, The Dalles, OR 97058

Acknowledgment and Consent

I understand that Keilman Dental Clinic, PC will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Keilman Dental Clinic, PC may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my doctor's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a "Notice of Privacy Practices" and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that I am entitled to receive a copy of /or any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Keilman Dental Clinic, PC Notice of Privacy Practices in effect is located in the magazine rack in the reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Confidentiality Issues:

Do we have permission to call and CONFIRM APPOINTMENTS by leaving a message on your cell phone, text or e-mail or with spouse or child?	YES	NO	initial _____
Do we have permission to call about PRE-MED, PERSCRIPTIONS by leaving a message on your phone or with spouse or child?	YES	NO	initial _____
Do we have permission to discuss treatment or account information with your spouse or child?	YES	NO	initial _____
Do we have permission to mail you a Reminder Card of your Periodic Exams and Cleanings?	YES	NO	initial _____

By signing below, I agree that I have reviewed and understand the information above and that I have been offered and or received a copy of the Notice of Privacy Practices.

Signed: _____ Date:_____

KEILMAN DENTAL CLINIC, PC

Medical Health History Form

Check all that apply

Heart Problems

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ High /Low Blood Pressure
- ☐ Artificial Heart Valves/Stents
- ☐ Irregular Heart Beat
- ☐ Rheumatic Fever
- ☐ Infective Endocarditis
- ☐ Congestive Heart Failure
- ☐ Pacemaker or Defibrillator
- ☐ Stroke, CVA, or TIA Date: _____
- ☐ Heart Attack Date: _____
- ☐ Bypass Surgery Date: _____
- ☐ Other Heart Surgery Date: _____
- ☐ Has your Primary Care Physician required you to take a pre-med antibiotic before Dental procedures?

Blood Disorders

- ☐ HIV/AIDS
- ☐ Bleeding disorder (Hemophilia)
- ☐ Methemoglobinemia
- ☐ Atypical Plasma cholinesterase
- ☐ Abnormal/prolonged bleeding
- ☐ Frequent nose bleeds
- ☐ History of blood transfusions

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ History of Tuberculosis
- ☐ History of COVID 19
- ☐ Persistent cough
- ☐ Sleep Apnea

Nerves/Muscles

- ☐ Myasthenia gravis
- ☐ Epilepsy
- ☐ History of fainting
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ Restless Leg Syndrome
- ☐ History of Sleep Walking
- ☐ Do you need assistance with walking
  - ☐ Yes ☐ No

Organs/Glands

- ☐ Acid Reflux
- ☐ Herpes/STD
- ☐ Crohn's disease
- ☐ Sjogren's disease
- ☐ Kidney Problems _____
- ☐ Liver Problems/Jaundice
- ☐ Hepatitis Type: _____
- ☐ Hyper/Hypo thyroid
- ☐ Diabetes
- ☐ Low Blood Sugar
- ☐ Family History of Diabetes
- ☐ Excessive Thirst or Frequency of urination

Head/Neck

- ☐ Glaucoma
- ☐ Arthritis
- ☐ Ear Surgery (inner)
- ☐ Head Injury Date: _____
- ☐ Artificial Joints
  - Where _____
  - Date of Placement: _____
  - Pre-Medication with Antibiotic ☐ Yes ☐ No
- ☐ Psychological or Personality disorder
  - Please list: _____
- ☐ Anxiety general/dental treatment
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Alzheimer's
- ☐ Dizziness
- ☐ Vertigo in a reclined position

Allergies

- ☐ Sinusitis/Sinus problems
- ☐ Hay fever/Seasonal allergies
- ☐ Latex
- ☐ Sulfites
- ☐ PABA (para aminobenzoic acid)
- ☐ Local Anesthetics
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa Drugs
- ☐ Codeine, Demerol, Narcotics
- ☐ Aspirin, Acetaminophen, Ibuprofen
- ☐ Sedatives, Barbiturates, Sleeping pills
  - Please list any & all other allergies

_____

_____

KEILMAN DENTAL CLINIC, PC

Medical Health History Form

Cancer

☐ Type_____ Stage _____
☐ History of Chemotherapy treatment
☐ History of Radiation treatment

Drugs

☐ Do you drink Alcohol
How much _____
☐ Do you use recreational drugs
How often _____
Which drugs _____
☐ History of drug/alcohol addiction

Women

☐ Taking birth control or other hormones
☐ Are you pregnant, If so due date _____
☐ Nursing
☐ Have you reached Menopause
If so, what are your symptoms _____

Please list any other condition, disease or problem/concern not listed above that you think we should know about.

Please List any & all medications including, over the counter, prescription, supplements, herbal remedies, medicinal marijuana, creams, etc.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set for the above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/Legal Guardian

_____
Date

Reviewed by/notes & Date:

KEILMAN DENTAL CLINIC, PC

Welcome to Our Office

**Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us ~ we will be happy to help!*

Patient Information (CONFIDENTIAL)

DATE_____

NAME _____ Birthdate ____/____/_____ Home Phone _____
Address _____ City _____ State/Zip _____
Email _____ Cell Phone _____ SSN# _____
Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐ Widowed ☐ Separated
Patient's Employer _____ Work Phone _____
Business Address _____ City _____ State/Zip _____
Spouse or Parent/Guardian's Name _____ Work Phone _____
Spouse or Guardian's Employer _____ City _____
Whom May we Thank for Referring you? _____

Person to Contact in Case of Emergency (living in same home) _____ Phone _____
Person to Contact in Case of Emergency (**not** living in same home) _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____ Cell Phone _____
Email (optional) _____ SSN # _____
Employer _____ Work Phone _____ Birthdate _____/_____/_____

Is this person currently a patient in our office? ☐ *Yes* ☐ *No* *Are there other family members?* ☐ *Yes* ☐ *No*

For your convenience, we offer the following methods of payment. Please check the option you prefer:
☐ Cash ☐ Personal Check ☐Care Credit ☐Visa ☐MasterCard ☐American Express ☐Discover

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____/_____/_____ SSN# _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Zip _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Co. Address _____ City _____ State/Zip _____

DO YOU HAVE ADDITIONAL INSURANCE ☐Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____
Birthdate _____/_____/_____ SSN# _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Zip _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Co. Address _____ City _____ State/Zip _____

KEILMAN DENTAL CLINIC, PC

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you may need to cancel your appointment. We require at least 24 hours' notice. This will allow another person who is waiting for an appointment to be scheduled into the cancelled slot. Keilman Dental Clinic PC will apply a $25.00 cancellation fee if notice is given in less than 24 hours.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO-SHOW. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a $25.00 fee for an office appointment NO-SHOW.

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full BEFORE the patient's next appointment. We do not submit these fees to insurance.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that a good provider/patient relationship is based upon understanding and good communication. Questions about cancellations and No-Show fees should be directed to the Billing Department. The contact telephone number for the Billing Department is (541) 296-1118.

PLEASE SIGN THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THE CANCELLATION AND NO-SHOW POLICY.

_____

Patient Name (Please Print)

_____ Date _____

Signature of Patient or Patient Representative