BECKLEY
FAMILY DENTAL GROUP

PERSONAL INFORMATION

This information is required to allow us to provide our treatment and services and will be considered **confidential**

Phone: 503-266-5596
503-263-1637 FAX
146 SW 2nd AVE Canby, OR 97013

Patient Name _____ Age _____ Birthday _____

Resident Address _____ Res. Phone _____

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Cell Phone _____

Drivers Lic. No. Social Security No. _____ Email _____

Employer: _____ Occupation _____

Business Address: _____ Bus. Phone _____

Spouse's Name _____ Driver's License No. _____ Social Sec. No. _____

Business Address: _____ Bus. Phone _____

Emergency Contact _____ Relationship _____

Resident Address: _____ Res. Phone _____

Name of Physician _____ Phone _____

Previous Dentist _____ Phone _____

Referred By _____ Phone _____

Person Responsible for this account _____ Relationship _____

Residence Address _____ Res. Phone _____

PAYMENT PREFERENCE: ☐ Cash ☐ Check ☐ Credit Card

PRIMARY INSURANCE: Name of Insurance Company _____

Name of Insured Person _____ Relationship to Patient _____

Name of Employer Group _____ Insurance Co. Phone _____

SECONDARY INSURANCE: Name of Insurance Company _____

Name of Insured Person _____ Relationship to Patient _____

Name of Employer Group _____ Insurance Co. Phone _____

OFFICE FINANCIAL POLICY

☐ **Payment options:** We require payment at the time services are rendered in our office. We realize that every person's financial situation is different. Therefore, we provide several different payment options to our patients. We accept cost, personal checks, or credit cards for your convenience. You are responsible for and agree to pay for all account collection costs. A $25 fee will be charged for all checks returned on my account from the bank. At the discretion of the dental office. A $50 fee will be charged if a 24 hour cancellation notice is not given.

☐ **Insurance:** Courtesy to our patients, w'e will gladly submit your insurance claims. However, we cannot guarantee any estimated coverage, since the insurance policy is an agreement between you and the insurance carrier.

All patients are expected to pay their estimated portion of the cost of services at the time the services are received. In some instances, the insurance plan may pay more or less than the estimate given. In those situations, we will notify you with a statement if there is a balance. or issue a refund if the insurance pays more than the estimate. A monthly statement will be sent to keep you informed of all account activity until the balance is paid in full. A service charge of 1.5% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 90 days. We do not accept assignment of insurance benefits when a patient comes in for consultation only, but we will submit your claim forms so you can receive any benefits that are available.

Due to the difficulty in dealing with certain insurance companies, there are some insurance plans that we do not accept assignment of benefits from. In these instances, we will submit your claim forms, so that the benefit payment will be sent to the insured.

If you have any questions about the financial aspect of your treatment, please speak with the Office Administrator.

☐ **Acknowledgements: I have read the above Office Financial Policy and agree to its content. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to my account. I understand that I am solely responsible for payments of all dental services provided by this office for myself or my dependents. I have received a copy of the office "Notice of Privacy Practices.**

Signed: _____ **Date:** _____

BECKLEY FAMILY DENTAL GROUP | MEDICAL HISTORY

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Patient Name _____ Phone Number _____

Address _____

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 receive. Thank you for answering the following questions.

PLEASE EXPLAIN ANY "YES" ANSWER.

Are you under a physician's care now?	☐ No	☐ Yes	_____
Have you ever been hospitalized or had a major operation?	☐ No	☐ Yes	_____
Have you ever had a serious head or neck injury?	☐ No	☐ Yes	_____
Are you taking any medication, pills or drugs?	☐ No	☐ Yes	_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ No	☐ Yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ No	☐ Yes	_____
Are you on a special diet?	☐ No	☐ Yes	_____
Do you wear contact lenses?	☐ No	☐ Yes	_____
Do you use Tobacco?	☐ No	☐ Yes	_____
Do you use controlled substances?	☐ No	☐ Yes	_____
Have you ever had any facial or oral piercings?	☐ No	☐ Yes	_____
Have you ever had any sensitivity or allergy to metal?	☐ No	☐ Yes	_____
Have you been treated for osteoporosis?	☐ No	☐ Yes	_____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Asprin ☐ Penicillin ☐ Metal ☐ Latex ☐ Codeine? ☐ Acrylic ☐ Erythromycin

☐ Sulfa drugs ☐ Tetracycline ☐ Local Anesthetics ☐ Other _____

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
AIDS/HIV Positive	☐	☐	Chemotherapy	☐	☐	Genital Herpes	☐	☐	Hypoglycemia	☐	☐
Alzheimer's Disease	☐	☐	Cold Sores/Fever Blisters	☐	☐	Glaucoma	☐	☐	Irregular Heartbeat	☐	☐
Anaphylaxis	☐	☐	Chest Pains	☐	☐	Hay Fever	☐	☐	Leukemia	☐	☐
Anemia	☐	☐	Congenital Heart Disorder	☐	☐	Heart Attack/Failure	☐	☐	Liver Disease	☐	☐
Angina	☐	☐	Convulsions	☐	☐	Heart Murmur	☐	☐	Low Blood Pressure	☐	☐
Arthritis/Gout	☐	☐	Cortisone Medicine	☐	☐	Heart Pace Maker	☐	☐	Lung Disease	☐	☐
Artificial Heart Valve	☐	☐	Diabetes	☐	☐	Heart Trouble/Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Artificial Joint	☐	☐	Drug Addiction	☐	☐	Hemophilia	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Easily Winded	☐	☐	Hepatitis A	☐	☐	Pain in Jaw Joints	☐	☐
Blood Disease	☐	☐	Emphysema	☐	☐	Hepatitis B or C	☐	☐	Parathyroid Disease	☐	☐
Blood Transfusion	☐	☐	Epilepsy or Seizures	☐	☐	Herpes	☐	☐	Psychiatric Care	☐	☐
Breathing Problems	☐	☐	Excessive Bleeding	☐	☐	High Blood Pressure	☐	☐	Radiation Treatments	☐	☐
Bruise Easily	☐	☐	Excessive Thirst	☐	☐	High Cholesterol	☐	☐	Recent Weight Loss	☐	☐
Cancer	☐	☐	Fainting Spells/Dizziness	☐	☐	Hives or Rash	☐	☐	Renal Dialysis	☐	☐
Rheumatic Fever	☐	☐	Shingles	☐	☐	Stomach/Intestinal Disease	☐	☐	Thyroid Disease	☐	☐
Rheumatism	☐	☐	Sickle Cell Disease	☐	☐	Stroke	☐	☐	Tonsilitis	☐	☐
Scarlet Fever	☐	☐	Sinus Trouble	☐	☐	Swelling of Limbs	☐	☐	Tuberculosis	☐	☐
Tumors or Growths	☐	☐	Ulcers	☐	☐	Venereal Disease	☐	☐	Yellow Jaundice	☐	☐

Have you ever had any serious illness not listed above? ☐ No ☐ Yes _____

How nervous are you regarding dental treatment ☐ Extremely ☐ Above Avg. ☐ Somewhat ☐ Not at all

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 change in medical status. I give the dental office permission to contact my physician regarding my current medical treatment and history.

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

BECKLEY
FAMILY DENTAL GROUP

PERSONAL MEDICATION FORM

Phone: 503-266-5596
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146 SW 2nd AVE Canby, OR 97013

Patient Name _____ Date of Birth _____

A complete medication history is important to your physicians. Please fill out this form and bring it with you anytime you go to the doctors office, if you are scheduled for treatment, make a trip to the emergency room, or are going to the hospital. Remember to bring this completed form.

Allergies: Are you allergic to Medications, Iodine, Food, Tape, or Latex?

ALLERGY	REACTION	ALLERGY	REACTION	ALLERGY	REACTION

Vaccines: Circle one for each vaccine

HEADER	HEADER	HEADER	HEADER
Within 10 Years	Within 5 Years	Within 1 Year	Up to Date
Unknown	Unknown	Unknown	Unknown

Medications: Please list ALL prescription and non-prescription medications, herbals, eye drops, nutritional supplements, inhalers, etc. that you use.

MEDICATION	DOSE	ROUTE (MOUTH, EYE..)	DIRECTIONS	PURPOSE (WHY TAKEN)

Medications: Recently prescribed not used on a frequent basis

MEDICATION	DOSE	ROUTE (MOUTH, EYE..)	DIRECTIONS	PURPOSE (WHY TAKEN)

Contact Information:

Doctor's Name: _____ Dr. Phone #: _____

Pharmacy: _____ Pharmacy Phone #: _____

Emergency Contact Name / Phone #: _____

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

Phone: 503-266-5596
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I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE STATEMENT OF PRIVACY PRACTICES FOR THE OFÑCES OF BECKLEY FAMILY DENTAL GROUP. THE STATEMENT OF PRIVACY PRACTICES DESCRIBES THE TYPES OF USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MIGHT OCCUR IN MY TREATMENT, PAYMENT FOR SERVICES, OR IN THE PERFORMANCE OF OFFICE HEALTH CARE OPERATIONS. THE STATEMENT OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND THE RESPONSIBILITIES AND DUTIES OF THIS OFFICE WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. THE STATEMENT OF PRIVACY PRACTICES IS ALSO POSTED IN THE FACILITY.

BECKLEY FAMILY DENTAL GROUP RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES CURRENTLY DESCRIBED IN THE STATEMENT OF PRIVACY PRACTICES. IF PRIVACY PRACTICES CHANGE, I WILL BE OFFERED A COPY OF THE REVISED STATEMENT OF PRIVACY PRACTICES AT THE TIME OF MY FIRST VISIT AFTER THE REVISIONS BECOME EFFECTIVE. I MAY ALSO OBTAIN A REVISED STATEMENT OF PÑVACY PRACTICES BY REQUESTING THAT ONE BE MAILED OR OTHERWISE TRANSMITTED TO ME.

ADDITIONAL DISCLOSURE AUTHORIZATION

IN ADDITION TO THE ALLOWABLE DISCLOSURES DESCRIBED IN THE STATEMENT OF PRIVACY PRACTICES, I HEREBY SPECIFICALLY AUTHORIZE DISCLOSURE AT MY PROTECTED HEALTHCARE INFORMATION TO THE PERSON(S) IDENTIFIED BELOW. (I UNDERSTAND THAT THE DEFAULT ANSWER IS “NO”. WITHOUT INDICATING “YES” IN ANSWER TO EACH INDIVIDUAL QUESTION, PROTECTED HEALTH INFORMATION (PHL) CANNOT BE SHARED WITH ANYONE UNLESS OTHERWISE ALLOWED BY HIPAA RULES.)

Spouse Only: ☐ Yes ☐ No

Any member of my immediate family: (i.e. Spouse, Children, Siblings, etc.) ☐ No ☐ Yes

Any member of my extended family: (i.e. Parents, Grandchildren) ☐ No ☐ Yes

Other: ☐ No ☐ Yes

Name of Patient (Print): _____

Patient Signature: _____

Patient’s Personal Representative (Print): _____

Personal Representative Signature: _____

Representative’s Phone Number: _____ Date: _____

OFFICE USE ONLY BELOW THIS LINE

ACKNOWLEDGEMENT NOT OBTAINED

- ☐ Provided Prior Treatment?
- ☐ Needed More Time to Review Statement
- ☐ Wanted to consult another Person prior to signing
- ☐ Physically unable to sign
- ☐ No reason offered
- ☐ Other:

If Other, please provide reason _____

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DENTAL HISTORY

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Patient Name _____ Age _____

Reffered by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient? _____

Date of most recent dental exam _____ Date of most recent x-rays _____

I routinely see my dentist every: ☐ 3 mo ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:

PERSONAL HISTORY

Are you fearful of dental treatment? How much on a 1-10 scale?	☐ No	☐ Yes	_____
Have you had a unfavorable dental experience?	☐ No	☐ Yes	_____
Have you ever had complications from past dental treatment?	☐ No	☐ Yes	_____
Have you ever had trouble getting numb or had reactions to anesthetic?	☐ No	☐ Yes	_____
Did you ever have braces, orthodontic treatment, or had bite adjustments? (IF YES What age?)	☐ No	☐ Yes	_____
Have you ever had teeth adjusted, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐ No	☐ Yes	_____

GUM AND BONE

Do your gums bleed sometimes or are they painful when brushing?	☐ No	☐ Yes	_____
Have you ever been treated for gum disease, had scaling or root planning or been told you have lost bone around your teeth?	☐ No	☐ Yes	_____
Have you noticed an unpleasant taste or odor in your mouth?	☐ No	☐ Yes	_____
Is there anyone with a history of periodontal disease in your family?	☐ No	☐ Yes	_____
Have you ever experienced a gum recession, or can you see more of the roots of your teeth?	☐ No	☐ Yes	_____
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐ No	☐ Yes	_____
Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐ No	☐ Yes	_____

TOOTH STRUCTURE

Have you had any cavities within the past 3 years?	☐ No	☐ Yes	_____
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐ No	☐ Yes	_____
Do you feel or notice any holes(i.e. pitting, craters) on the biting surface of your teeth?	☐ No	☐ Yes	_____
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐ No	☐ Yes	_____
Do you have grooves or notches on your teeth near the gum line?	☐ No	☐ Yes	_____
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐ No	☐ Yes	_____
Do you frequently get food caught between any teeth?	☐ No	☐ Yes	_____

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DENTAL HISTORY (CONT.)

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PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:

BITE AND JAW JOINT

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐ No	☐ Yes	
Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐ No	☐ Yes	
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐ No	☐ Yes	
In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐ No	☐ Yes	
Are your teeth becoming more crooked, crowded, or overlapped?	☐ No	☐ Yes	
Are your teeth developing spaces or becoming more loose?	☐ No	☐ Yes	
Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐ No	☐ Yes	
Do you place your tongue between front teeth or close your teeth against your tongue?	☐ No	☐ Yes	
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐ No	☐ Yes	
Do you clench or grind your teeth together in the daytime or make them sore?	☐ No	☐ Yes	
Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐ No	☐ Yes	
Do you wear or have you ever worn a bite appliance?	☐ No	☐ Yes	

SMILE CHARACTERISTICS

Is there anything about the appearance of your mouth (Smile, Lips, Teeth, Gums) that you would like to change: (Shape, Size, Color, Display)?	☐ No	☐ Yes	
Have you ever bleached (Whitened) your teeth?	☐ No	☐ Yes	
Have you ever felt self-conscious or uncomfortable about your teeth?	☐ No	☐ Yes	
Have you ever been disappointed with the appearance of previous dental work?	☐ No	☐ Yes	

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

BECKLEY
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DENTAL RECORDS RELEASE FORM

Phone: 503-266-5596
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I, (print patient or guardian name)_____ , hereby authorize the doctor and staff of Dr. Stefanie Beckley DMD to receive records or knowledge concerning my dental health to (select one):

_____ 1. Given directly to me

_____ 2. Sent directly to a dental office email: scheduling@beckleysmiles.com - Dr. Stefanie Beckley

_____ 3. Given to a guardian (if patient is a minor) I am requesting that you release the following (check 1 or both):

_____ All X-Rays

_____ Most Current X-Rays

_____ All treatment notes

I understand that I have the right to revoke this authorization at any time by providing written notice to the organization.
I also understand that revocation is not applicable to information already disclosed while the authorization was in effect.

Signed: _____ **Date:** _____

146 SW 2ND AVE - CANBY, OR 97013
PHONE: (503) 266- 5596
FAX: (503) 263-1637
PLEASE EMAIL RECORDS TO:
SCHEDULING@BECKLEYSMILES.COM