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 call us.
We will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient information (confidential)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ Prov/State _____ Zip/P.C _____
Email _____ Cell Phone _____
Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/ Prov _____ Full Time ☐ Part Time ☐
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ Prov/State _____ Zip/P.C _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer Payment in full at each appointment.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birth date _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local#. _____ Work Phone _____
Address of employer _____ City _____ Prov/State _____ Zip/P.C _____
Insurance Company _____ Group# _____ Police/ID# _____
Ins.Co.Address _____ City _____ Prov/State _____ Zip/P.C _____
How much is your deductible? _____ How much have you used?. _____ Max.Annual Benifits _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ NO IF YES, COMPLETES THE FOLLOWING:
Name of Insured _____ Relationship to Patient _____
Birth date _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local#. _____ Work Phone _____
Address of employer _____ City _____ Prov/State _____ Zip/P.C _____
Insurance Company _____ Group# _____ Police/ID# _____
Ins.Co.Address _____ City _____ Prov/State _____ Zip/P.C _____
How much is your deductible? _____ How much have you used?. _____ Max.Annual Benifits _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2.Have you ever been hospitalized for any surgical operation or serious illness within the last 5years	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication (s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra. Revati, Cialis orLevitra in the last 24 hours ?	☐	☐
7. Do you use tobacco ?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐
12.Do you have a persistent cough or throat clearing not associated with a known illness Ousting more than 3 weeks)?	☐	☐
13.Women Only:		
a. An you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizure	☐	☐	Frequently tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsion	☐	☐	Cancer	☐	☐	Recent weight loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver disease	☐	☐
Diabetics	☐	☐	Joint replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	sexually transmitted Disease	☐	☐	Mitral Value Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10.Do you bite your lips or cheeks frequently?	☐	☐
11.Have you ever had any difficult extractions in the past?	☐	☐
12.Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

_____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____

Signature Date

Financial Policy Acknowledgement

In the interest of excellent dental care, it is our desire to establish a financial policy to avoid any misunderstandings. Our primary goal is to provide our patients with high quality dental care with expertise, individual attention, and kindness.

Patient responsibility plays a big role in successful treatment. Attending scheduled visits, following and performing dental home care recommendations results in a winning smile for years to come.

- All accounts are due and payable at the time of your visit unless other arrangements have been made with our Office Manager.

- For patients with insurance, we will gladly bill your insurance for you as a courtesy, when you provide the necessary information. We will accept payment directly from the insurance company only for that percentage the company has estimated to cover. The insurance companies are very clear when they give any information regarding your coverage. They use a disclaimer that states "*all claims are subject to eligibility and plan provisions at the time the services are rendered. This is not a guarantee of coverage*". We do our best to contact your insurance company and get an insurance breakdown over the phone. With this information we are able to ***estimate*** your benefits and your portion. We encourage our patients to become familiar with their insurance benefits so as to ensure an understanding of the details of your benefits. We do require that you pay for the deductible and any non-covered fees at the time services are provided.

- We do our best to confirm our patients by phone as well as postcards. We understand that situations occur that may hinder you from keeping your appointment. However, we do require 48 hours notice for any cancellation. Failure to provide 48 hour notice for cancellation may result in a minimum $35 cancellation fee. We strive to provide superior dental care at affordable cost by being efficient. When we are given prior notice of a cancellation we can reschedule your appointment and let another patient have the appointment time that was originally scheduled for you. Thank you for your cooperation in advance. Having understanding patients enables us to better serve the needs of all our patients.

I have read this financial policy and understand that payment is due at the time services are rendered. I also understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I give J. Michael Furgason, DDS permission to bill my insurance to collect any benefits due for charges incurred by me or my policy benefactors.

Print Name _____

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES:

J. Michael Furgason, O.D.S.
1507 Coburg Road, Eugene, OR 97401
541-687-1442
541-344-2983
eugenesmiles@comcast.net

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices This Notice describes how we protect your health information and what rights you have regarding it

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations Examples of how we use or disclose information for treatment purposes are setting up an appointment for you, examining your teeth, prescribing medications and (axing them to be filled; referring you to another doctor or clinic for other health care or services, or getting copies of your health information from another professional that you may have seen before us Examples of how we use or disclose your health information for payment purposes are asking you about your health or dental care plans, or other sources of payment, preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney) "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are financial or billing audits, internal quality assurance, personnel decisions; participation in managed care plans, defense of legal matters, business planning; and outside storage of our records

We routinely use your health information inside our office for these purposes without any special permission If we need to disclose your health information outside of our office for these reasons.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all Such uses or disclosures are;

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes such as contagious disease reporting, investigation or surveillance and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
- uses and disclosures for health oversight activities, such as for the licensing of doctors, for audits by Medicare or Medicaid, or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as lo provide information about someone who is or is suspected to be a victim of a crime: to provide information about a crime at our office or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death or to funeral directors to aid in burial, or to organizations that handle organ or tissue donations.
- uses or disclosures for health related research.
- uses and disclosures to prevent a serious threat to health or safety.
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials, for lawful national intelligence activities for military purposes, or for the evaluation and health of members of the foreign service
- disclosures of de-identified information.
- disclosures relating to worker's compensation programs.
- disclosures of a "limited data set:" for research, public health, or health care operations.
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.

- disclosures to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and for leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form” The content of an “authorization form” is determined by federal law Sometimes, we may initiate the authorization process if the use or disclosure is our idea Sometimes you may initiate the process if it’s your idea for us to send your information to someone else Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours If we initiate the process and ask you to sign an authorization form, you do not have to sign it If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one. you may revoke it at any time unless we have already acted in reliance upon it Revocations must be in writing Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- The law gives you many rights regarding your health information. You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice
- ask us to communicate with you in a confidential way. such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address We will accommodate these requests if they are reasonable, and if you pay us for any extra cost If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice
- ask to see or to get photocopies of your health information By law. there are a few limited situations in which we can refuse to permit access or copying For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off site) You may have to pay for photocopies in advance If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available By law we can have one 30 day extension of me time for us to give you access or photocopies if we send you a written notice of the extension If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mall shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete If we agree we will amend the information within 60 days from when you ask us We will send the corrected information to persons who we know got the wrong information, and others that you specify If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information By law. we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you Want). By law, the list will not include disclosures for purposes of treatment payment or health care operations, disclosures with your authorization incidental disclosures, disclosures required by law: and some other limited disclosures You are entitled to one such list per year without charge If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it but by law we can have one 30 day extension of time if we notify you of the extension in writing If you want a list send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services. Office for Civil Rights We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice If you prefer, you can discuss your complaint in person or by phone

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Tear here

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Michael Furgason Notice of Privacy Practices

Patient name _____

Signature _____ Date _____