

# Welcome

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)

Patient # \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Date \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ 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 \_\_\_\_\_ State/Prov. \_\_\_\_\_ 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 \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain) .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? .....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux? .....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? .....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? .....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Latex Rubber .....	<input type="checkbox"/>	<input type="checkbox"/>
			Other (please list) _____		
			12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? .....	<input type="checkbox"/>	<input type="checkbox"/>
			13. Women Only:		
			a) Are you pregnant or think you may be pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking oral contraceptives? .....	<input type="checkbox"/>	<input type="checkbox"/>

  

High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face) .....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing .....	<input type="checkbox"/>	<input type="checkbox"/>			

# 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.

**X** \_\_\_\_\_  
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, D.D.S.  
1507 Coburg Road, Eugene, OR 97401  
541-687-1442  
541-344-2983  
eugenesmiles@comcast.net  
Pat Ahrens~ Office Administrator

**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 faxing 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, [EDIT: [we will] [we usually will not]] ask you for special written permission.

[EDIT: [We will ask for special written permission in the following situations: \_\_\_\_\_]]

**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 to 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;
- [EDIT: [specify other uses and disclosures affected by state law] ]

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/or 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 the 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 mail 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.

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#### ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of [EDIT: Dr. Name] Notice of Privacy Practices.

Patient name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_