Mary K. Parent DMD, LLC
730 SE Oak Street, Suite C
Hillsboro, OR 97123
(503) 640-1056 Office
(503) 640-8846 Fax

Date _____

PATIENT INFORMATION

Name _____
Last Name First Name Middle How do you wish to be addressed?

Address _____ City _____ State _____ ZIP _____

Home Phone (_____) _____ Mobile Phone (_____) _____ Work Phone (_____) _____

AGE _____ DOB _____ SS # _____ E-Mail Address _____

Sex ☐ M ☐ F ☐ Other _____

☐ Single ☐ Married ☐Separated ☐ Divorced ☐ Widowed ☐ Minor/Dependent ☐ Partnered for _____ Months / Years

Employer _____ Occupation _____ Student ☐ Yes ☐ No

Employer Name _____ Address _____ Phone _____

If Patient is a Minor/Dependent Name of the Parent or Legal Guardian _____

Best Contact Number _____ Best E-Mail Address _____

In case of emergency who should be notified? Name _____ Phone _____

Who Referred you to our Office or How did you hear about us? _____

RESPONSIBLE PARTY / PRIMARY DENTAL INSURANCE

Person Responsible for This Account _____
Last Name First Name Middle

Relation to Patient _____ DOB _____ SS # _____

Address (If different from patient's) _____ City _____ State _____ Zip_____

Person Responsible Employer _____ Occupation _____

Business Address _____ Mobile Phone (_____) _____

Insurance Company _____ Plan Name _____

Subscriber # (Member ID) _____ Group # _____

ADDITIONAL / SECONDARY INSURANCE

Is patient above covered by additional or secondary insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ DOB _____

Address (If different from patient's) _____ City _____ State _____ Zip_____

Subscriber Employed by _____ Mobile Phone_____

Insurance Company _____ Plan Name _____

Plan Name _____Subscriber# _____ Group # _____

Names of other dependents covered under this plan _____

Subscriber # (Member ID) _____ Group # _____

Please Complete Above Information and Additional Pages

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MEDICAL HISTORY

Primary Physicians Name _____ Phone _____

Date of Last Visit _____ Last Seen For _____

Do you have a serious illness or disease? ☐ Yes ☐ No If Yes, What _____

Have you been Hospitalized in the past (2) years? ☐ Yes ☐ No If Yes, When/Where _____

For What _____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Have you ever had any of the following? (Check any that apply)

☐ Alcohol Use	☐ Cortisone Treatments	☐ Heart Attack	☐ Respiratory Disease
☐ Anemia	☐ Cough, Persistent	☐ Heart Murmur	☐ Rheumatic Fever
☐ Angina Pectoris	☐ Cough up Blood	☐ Heart Problems	☐ Scarlet Fever
☐ Arthritis	☐ Diabetes	☐ Heart Valve	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Dizziness	☐ Hemophilia	☐ Sinus Problems
☐ Artificial Joints	☐ Drug Use	☐ Hepatitis	☐ Skin Rash
☐ Asthma	☐ Eating Disorder	☐ High Blood Pressure	☐ Stroke
☐ Back Problems	☐ Epilepsy	☐ HIV-AIDS	☐ Surgery
☐ Blood Disease	☐ Emphysema	☐ Hypoglycemia	☐ Swelling of Feet or Ankles
☐ Bruise Easily	☐ Fainting	☐ Jaw Pain	☐ Thyroid Problems
☐ Cancer	☐ Frequent Thirst	☐ Kidney Disease	☐ Tobacco Use
☐ Chemical Dependency	☐ Frequent Urination	☐ Liver Disease	☐ Tonsillitis
☐ Chemotherapy	☐ GI Issues	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Circulatory Problems	☐ Glaucoma	☐ Pacemaker	☐ Ulcer
☐ Cold Sores	☐ Headaches	☐ Radiation Treatment	☐ STD's

Have you ever had an adverse reaction or are allergic to any medication or substance? (Check any that apply)

☐ Aspirin	☐ Erythromycin	☐ Latex	☐ Novocain	☐ Sulfa Drugs	☐ Valium
☐ Codeine	☐ Iodine	☐ Nitrous Oxide	☐ Penicillin	☐ Tetracycline	☐ Xylocaine

Do You have an Allergy or a Medical Condition Not listed Above that we should know about?

_____

List ALL Medications you are currently taking: _____

_____

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DENTAL HISTORY

Previous Dentist _____
Name Address Phone

Date of last dental visit _____ Date of last X-Rays _____

Do you currently have or have had problems with any of the following? (Check any that apply)

☐ Bad Breath	☐ Clenching Teeth	☐ Loose Teeth	☐ Periodontal Treatment
☐ Bleeding Gums	☐ Food Collection Between Teeth	☐ Loose or Lost Crown	☐ Sensitivity to Hot or Cold
☐ Bridge Broken or Missing	☐ Grinding Teeth	☐ Missing Filling	☐ Sensitivity to Pressure
☐ Broken Teeth	☐ Headaches	☐ Missing Teeth	☐ Sensitivity to Sweets
☐ Chipped Teeth	☐ Jaws Clicking or Popping	☐ Pain when Biting	☐ Sores or Growth in Mouth

Do you have any other problem or condition Not listed above which we should know about?

_____

_____

Do you currently have or have had problems with any of the following? (Check any that apply)

Are you happy with the appearance of your teeth? ☐ Yes ☐ No	Do you floss daily or between meals? ☐ Yes ☐ No
Would you like your teeth to be whiter? ☐ Yes ☐ No	Do you feel you have cavities? ☐ Yes ☐ No
Have you avoided regular dental care? ☐ Yes ☐ No	Do you feel you have gum disease? ☐ Yes ☐ No
Do you brush daily or between meals? ☐ Yes ☐ No	Have you ever had Periodontal (Gum) Treatments? ☐ Yes ☐ No

How often do you have your teeth cleaned and examined? ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Every Few Years ☐ Very Seldom

My Previous dental experience has been ☐ Positive ☐ Neutral ☐ Negative

For me going to the Dentist is: ☐ Fun ☐ Just Ok ☐ Absolutely Dreadful

Reason for your visit today? _____

What dental care would you like to get accomplished today or very soon (In the next 2 weeks)?

_____

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AUTHORIZATION AND CONSENT

I hereby authorize Mary K. Parent DMD and dental staff to administer any treatment and to administer x-rays, anesthetics and to perform dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I understand the use of anesthetic agents embodies certain risk. Mary K. Parent DMD, LLC may use my heath care information and may disclose such information to other medical providers and insurance companies and their agents for the purpose of obtaining services or payment for services and determining benefits or the benefits payable for services rendered. I authorize release of any information related to claims and I authorize the use of my signature on all insurance submissions and claims. I authorize and assign directly to Mary K. Parent DMD, LLC all insurance benefits otherwise payable to me to be paid directly to Mary K. Parent DMD, LLC and/or my provider of record. I understand that I am financially responsible for any and all charges whether or not paid by insurance. Payment is due in full at the time of treatment/service unless prior arrangements have been approved. In cases where insurance has been billed all balances are due at time of service and may incur additional finance charges or fees after 30 days on all unpaid or uncollected balances. Charges will be assessed per occurrence for missed or cancelled appointments that occur within 48 hours prior to a scheduled appointment. This consent will remain in effect as long as I am a patient of record or have a balance on account.

Signature _____ Date _____
Patient, Parent, Guardian or Personal Representative

MARY K. PARENT, DMD, LLC
FAMILY DENTISTRY

FINANCIAL ACKNOWLEDGEMENT

Our Commitment is to serve our dental patients so that they may achieve a greater level of overall health and well-being by enhancing their appearance, comfort and function.

IF YOU ARE NOT INSURED:

Payment, in full, is due at the time you receive your services. You are welcome to put a credit card on file below. We accept **VISA**, **MASTERCARD, DISCOVER**, and we also accept **Care Credit.** Care Credit Offers various deferred or interest free payment plans. For more information regarding Care Credit ask us how to apply.

IF YOU ARE INSURED:

Please give your insurance information when scheduling and bring the insurance card and photo ID along with the completed insurance form to your first visit. You may also email this information ahead of time to: MKP.DMD@frontier.com. Payment of your deductible and the estimated portion your insurance does not cover; your co-pay, is expected at the time of service. We provide insurance billing as a service to you. It is your responsibility to let us know if your insurance changes. Your insurance policy is a contract between you and that insurance company. We are not able to negotiate with your insurance company on your behalf.

AUTHORIZATION & ACKNOWLEDGEMENT:

We charge what is usual and customary for our area. Please be aware that some of the services we provide may or may NOT be covered by your dental plan. You are responsible for the entire balance if your insurance company does not pay our office within 30 days. Balances over 90 days may be assigned to a collection agency and may incur a collection fee of $75.00. Any checks returned to our office for non-sufficient funds will be subject to a fee of $35.00. I hereby authorize release of any relevant information necessary to process my claim to my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to Mary K. Parent, DMD, LLC.

_____ _____

(Signature of Patient or Responsible Party) (Date)

MINOR PATIENTS:

If a minor is not accompanied by their parents or legal guardian, arrangements for payment needs to be made prior to the appointment. I have read the Policy Acknowledgment and understand that as a patient or legal guardian of a minor patient, I agree to pay all services rendered in accordance with the terms and conditions set for in the financial policy of this office as stated above.

_____ _____

(Signature of Responsible Party) (Date)

I understand that, regardless of my insurance coverage, I am responsible for payment of services rendered and that a financial charge of 1.5% will be applied, per month, to accounts over 30 days or more. I authorize Mary K. Parent DMD, LLC to submit charges to cover balance over 30 days or more.

CREDIT CARD ON FILE:

VISA - MC - DISCOVER - Care Credit #: _____ - _____ - _____ - _____ EXP: _____/_____

_____ _____ CVC: _____

(Signature of Patient or responsible party) (Date)

Mary K. Parent DMD, LLC

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(503) 640-1056 Office
(503) 681-8846 Fax

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Authorization to release Dental Information

The patient herein gives the office of Dr. _____
Permission to forward all dental records to the doctor indicated on this form.

PATIENT INFORMATION:

Name: _____

Date of birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

SEND RECORDS TO:

Name of Dentist or Person: **Mary K. Parent DMD, LLC**

Street Address: **730 SE Oak Street, Suite C**

City: **Hillsboro** State: **OR** Zip: **97123**

Office Phone Number: **503-640-1056** Fax: **503-681-8846**

Email: **mkp.dmd@frontier.com**

The above named is authorized to release my dental records as indicated.

PATIENT SIGNATURE: _____ DATE: _____

PARENT SIGNATURE: _____ DATE: _____