BENJAMIN T. PETERSON, DDS, PC
271 SW 13th St. | Ontario, OR | 97914
(541) 889-9407 | www.bpetersondds.com

Welcome to Our Office!

Our office is committed to providing the highest quality dental care at a reasonable cost. Thank you for trusting us with your care. Please take a few minutes to read and complete the following forms. If you have any questions or need assistance, please feel free to ask. Once again, welcome!

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy with respect to my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in my treatment, directly and indirectly.
2. Obtain payment from insurance companies or third-party payors.
3. Conduct normal healthcare operations such a quality assessments and physician certifications.

I have received, read and understand this *Notice of Privacy Practices*. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of its *Notice of Privacy Practices*.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand that this office is not required to agree to my requested restrictions, and that if this office does agree that it is bound by such restrictions.

Failed Appointment / Cancellation Policy

Failure to appear for a scheduled appointment or cancellations made within 24 hours of an appointment may result in a fee according to the procedure and the amount of time reserved for you or dismissal from our office.

Acknowledgment

By my signature below I acknowledge that I have read and understand the foregoing *Notice of Privacy Practices* and Failed Appointment / Cancellation Policy:

_____ _____

Signature of Patient or Responsible Party Date

_____

Please Print Name of Patient or Responsible Party

PATIENT MEDICAL HISTORY

Benjamin T. Peterson, DDS

Patient Name: _____ Date of Birth: _____

*e-mail address:*_____ *Contact Phone#:* _____

Medical Physician's Name: _____ Date of last medical exam: _____

Are you currently under medical treatment? ☐ Yes ☐ No If yes, please explain: _____

Have you been hospitalized for any surgical operation or serious illness in the last 5 years? ☐ Yes ☐ No
If yes, please briefly explain and give dates: _____

Have you ever taken medication for Osteoporosis? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No
Do you suffer from daytime sleepiness? ☐ Yes ☐ No
Have you ever been diagnosed with a sleep disorder or sleep apnea? ☐ Yes ☐ No
Have you had a sleep study? ☐ Yes ☐ No
Have you failed a CPAP? ☐ Yes ☐ No

Are you allergic to or have you had any reactions to the following:

Local anesthetics	☐ **Yes** ☐ **No**	**Sulfa drugs**	☐ **Yes** ☐ **No**
Penicillin	☐ **Yes** ☐ **No**	**Any metals**	☐ **Yes** ☐ **No**
Codeine	☐ **Yes** ☐ **No**	**Latex rubber**	☐ **Yes** ☐ **No**

Other: _____

Women Only:
Are you pregnant or think you might be pregnant? ☐ Yes ☐ No If Yes, estimated due date: _____
Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No

Please list any medications you are taking, including non-prescribed medications, and the dosage you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Low blood pressure	☐	☐	Epilepsy/convulsions	☐	☐	Hepatitis/Jaundice	☐	☐
High blood pressure	☐	☐	Diabetes	☐	☐	Sexually Trans Disease	☐	☐
Heart Attack	☐	☐	Kidney disease	☐	☐	AIDS/HIV	☐	☐
Heart Disease	☐	☐	Thyroid problems	☐	☐	Ulcer/Stomach Trouble	☐	☐
Artificial heart valve	☐	☐	Respiratory problems	☐	☐	Stroke	☐	☐
Heart murmur	☐	☐	Emphysema	☐	☐	Cancer	☐	☐
Mitral valve prolapse	☐	☐	Hay fever/Allergies	☐	☐	Radiation therapy	☐	☐
Pacemaker	☐	☐	Anemia	☐	☐	Recent weight loss	☐	☐
Circulatory problems	☐	☐	Back problems	☐	☐	Liver disease	☐	☐
Fainting/Seizures	☐	☐	Arthritis	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Artificial joints	☐	☐	Other: _____		
Tobacco use	☐	☐	Weight loss medication	☐	☐			

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Blood Press Pulse

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Blood Press Pulse

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Blood Press Pulse

BENJAMIN T. PETERSON, DDS, PC

General Dentistry for the Treasure Valley

PATIENT INFORMATION Date: _____

Patient Name: _____

Address: _____

City: _____ State:____ Zip: _____

Gender: □ Male □ Female Age: _____

Birthdate: _____ SSN: _____

□ Married □ Single □ Other □ Minor

Patient Employer: _____

Email address: _____

Spouse or Parent(s) Name:

_____

Whom may we thank for referring you to our office?

_____

DENTAL INSURANCE

Insurance Company: _____

Subscriber's Name: _____

Birthdate: _____ SSN: _____

Policy/ID#: _____ Group#: _____

Relationship to patient: _____

SECONDARY INSURANCE? □ Yes □ No

Insurance Company: _____

Subscriber's Name: _____

Birthdate: _____ SSN: _____

Policy/ID#: _____ Group#: _____

PHONE NUMBERS Home: _____ Cell: _____ Work: _____

Which number would you prefer to be reached at? Home Cell Work

Emergency Contact: _____ Relationship: _____ Phone: _____

PAYMENT POLICY Payment is expected at the time services are rendered unless prior arrangements have been made. We expect that your account will be cleared within 60 days. If financial arrangements have been made, the remaining unpaid balance may be subject to a FINANCE CHARGE at the ANNUAL PERCENTAGE RATE of 18%. There will be a $25 fee for all returned checks.

INSURANCE ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have the insurance coverage referenced above and assign directly to Benjamin T. Peterson, DDS, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Benjamin T. Peterson, DDS, PC, may use my health care information and may disclose such information to the above-named insurance company and its agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This release of information will remain in effect until revoked by me in writing.

_____ _____

Signature of Patient or Responsible Party Please print name of Patient or Responsible Party

_____ _____

Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

Are you happy with the condition of your teeth? □Yes □ No

If not, why? _____

_____

_____

_____

Check (√) if you have had problems with any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping of the jaw
□ Food collection between teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Grinding teeth
□ Sensitivity to cold
□ Snoring
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in mouth

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Financial Policy

Dear Patient:

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health at an affordable cost. If you have any questions or concerns about our policies, please do not hesitate to ask.

Regarding Payment Methods

To provide our patients as much flexibility as possible, **the following payment options are available;**

1. Payment in Full at Time of Service:

- ***8% discount will be given for accounts paid in full at time of service with cash or check.***
- ***5% discount if the balance is paid in full with a credit card.***
- If dentures, partial dentures, crowns and bridges are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is **due** at the time the prosthesis is cemented or inserted.

2. Short Term Payment Options:

- 30% down payment of the estimated treatment plan is required at the start of treatment.
- Remaining balance can be divided into **up to six equal monthly payments,** *with no interest charged*.
- Payments can be made through the use of pre-authorized credit card or debit card payments. You will simply pre-authorize a specific monthly payment and the day of the month, and our office will process your payment.

3. Extended Payment Option:

- If you would like an extended payment plan, extending your payments beyond six months, you can apply for the following options;

-Care Credit	-American General Financial
-Capital One Health Card	-Citi Health Card

Regarding Insurance

Please be aware that some of the services provided may be non-covered services and/or not considered reasonable and customary under the terms of your insurance policy. You are responsible for payment regardless of any insurance company's arbitrary determination of approved charges and services.

Once again, thank you for choosing our office. We are fully committed to providing excellent, appropriate and affordable dental care to our patients. If you have any questions or concerns about our policies, please do not hesitate to ask.

I have read the Financial Policy. I understand and agree to this Financial Policy.
Signature of Patient or Responsible Party:_____**Date:**_____