30045 SW Parkway Ave
Wilsonville, Oregon 97070
www.vangordon.com

Van Gordon
DENTISTRY

503.682.2455
info@vangordon.com

Patient Information

Title First Name M.I. Last Name Date

I prefer to be called Email:

Address City State Zip

Home Phone Cell Phone Business Phone Ext.

Preferred Contact # Social Security # **Gender** ☐ Male ☐ Female

Date of Birth / / **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you find out about us?

Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix

Relationship to Patient

Home Phone Cell Phone Business Phone Ext.

Responsible Party / Patient

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:

Title First Name M.I. Last Name Suffix

Address City State Zip

Home Phone Business Phone Ext.

Date of Birth / / Social Security # Driver's License #

Employer

Primary Dental Insurance

Do you have a Primary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No

Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #)

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Secondary Dental Insurance

Do you have a Secondary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No

Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #)

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Dental Information

Previous or Referring Dentist: _____ Phone Number: _____

When was your last dental visit? _____ _____ What was done? _____

When were x-rays taken last? _____ _____ **When was your last dental cleaning?** _____ _____

Reason for today's visit: _____ **Are you in pain?** ☐ Yes ☐ No For how long? _____

Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How do you feel about your smile? _____

Are you fearful of dental treatment? ☐ Yes ☐ No Please explain: _____

Have you ever had trouble getting numb or had reactions to local anesthetic?	☐ Yes	☐ No
Please describe: _____		
Do your gums bleed?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	☐ Yes	☐ No
Have you noticed any bad tastes or bad breath?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?	☐ Yes	☐ No
Have you had orthodontic (braces) treatment?	☐ Yes	☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes	☐ No
Do you have earaches or neck pains?	☐ Yes	☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes	☐ No
Have you noticed any loose or shifting teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had headaches on a regular basis in the morning, evening, or after eating?	☐ Yes	☐ No
Have you had your bite adjusted?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes	☐ No
Do you use a CPAP machine or snoreguard?	☐ Yes	☐ No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam _____ _____ **Are you now under the care of a physician?** ☐ Yes ☐ No

Current Physician

What condition is being treated? _____

Physician Name _____ **Phone Number** _____

Address _____ City _____ State _____ Zip _____

For Women

Are you pregnant? ☐ Yes ☐ No How many weeks? _____

Taking birth control pills or hormonal replacement? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No

What was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No

Please list any medications (prescription or over the counter) you are taking:

Name	_____	For what condition?	_____	Dosage	_____
Name	_____	For what condition?	_____	Dosage	_____
Name	_____	For what condition?	_____	Dosage	_____
Name	_____	For what condition?	_____	Dosage	_____
Name	_____	For what condition?	_____	Dosage	_____
Name	_____	For what condition?	_____	Dosage	_____
Name	_____	For what condition?	_____	Dosage	_____
Name	_____	For what condition?	_____	Dosage	_____

Do you need antibiotics prior to receiving dental care? ☐ Yes ☐ No Reason: _____

Do you take or have you taken Phen-Fen or Redux? ☐ Yes ☐ No **Are you on a special diet?** ☐ Yes ☐ No

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began:

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How much do you typically drink in a week?

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics	☐ Yes ☐ No	Details:	
Aspirin	☐ Yes ☐ No	Details:	
Penicillin or other antibiotics	☐ Yes ☐ No	Details:	
Barbiturates, sedatives, or sleeping pills	☐ Yes ☐ No	Details:	
Sulfa drugs	☐ Yes ☐ No	Details:	
Codeine or other narcotics	☐ Yes ☐ No	Details:	
Metals	☐ Yes ☐ No	Details:	
Latex (rubber)	☐ Yes ☐ No	Details:	

Other

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

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

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Please explain:

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____

Brock A. Van Gordon, DMD, PC
30045 SW Parkway Avenue
PO Box 3680
Wilsonville, OR 97070
(503) 682-2455

Dr. Van Gordon and his team are committed to providing you with friendly and caring service. We will do our best to make your visit with us as comfortable as possible. Our team undergoes continuous training to bring dentistry's latest improvements into our office to provide the best services available to our patients. We look forward to establishing a long-term relationship with you as your dental care provider.

Billing of Services
As a courtesy, we will submit bills directly to your insurance company with our assignment of benefits so that payment can be made on your behalf. We will also be happy to bill more than one insurance company for you. Treatment estimates are not a guarantee of payment by your insurance company. We are not responsible for incorrect information supplied to us by your insurance carrier. It is your responsibility to confirm your benefits with your carrier.

We do our best to give an accurate estimate and encourage you to familiarize yourself with your insurance plan and even contact them if necessary. Upon your request we are happy to supply you with a benefits page to assist you in verifying coverage and benefits.

Initial_____ Your cooperation in giving complete information to the admitting team members at each of your visits will help you get your insurance claim paid in a timely manner.

Payment of Services
Although we will bill your insurance and make all reasonable efforts to obtain payment from them, we will look to you for payment in full if there is a delay in payment of your claim or if your claim is denied. If your insurance has not paid after 60 days, you will be responsible for the balance. You are

Initial_____ ultimately responsible for payment of your dental bills regardless of the type of insurance coverage.

Payment Options
We accept major credit cards as a convenience to you. Accounts that reach 30 days past due will be billed a finance charge of 18% based on the average daily balance. For patients wishing to make

Initial_____ monthly payments, a billing service is available which offers a monthly payment plan.

Appointment Policy
We will gladly change appointment times to accommodate your schedule. However, we will need adequate notice prior to your appointment since we have reserved this appointment time only for you. A 48-hour notice is required for an appointments needing to be cancelled or rescheduled. **If**

Initial_____ **insufficient notice is given, a fee of $40.00 may be applied for each 30 minutes of appointment time missed.**

I have read the above conditions of treatment and agree to their content.

Signature _____

Brock A. Van Gordon, D.M.D., P.C.
Family & Cosmetic Dentistry

30045 SW Parkway Ave.
Wilsonville, OR 97070
(503) 682-2455

Insurance General Information

To avoid misunderstandings regarding dental insurance, we would like our patients to know that all professional services rendered in this office are charged directly to the patient, who is ultimately responsible for payment of any and all fees. If your dental insurance company fails to pay their portion or fails to pay the claim within 60 days. You are responsible for payment of balance due in full for any service rendered.

Your insurance contract is a financial agreement between you and your employer, not our office. Although we strive to collect accurate information and give correct estimates. It is ultimately your responsibility to know your dental benefits.

Our office provides a variety of flexible payment alternatives for the patient portion of the balance due, which make it affordable to receive dental care. Unless alternative financial arrangements are made in advance, payment is due when services are rendered.

Initial _____

How We Process Dental Insurance Claims

1. When the service is rendered, the **estimated** patient co-payment is collected.
2. The claim form is electronically sent to the insurance company along with any x-rays, intra-oral camera photographs or other necessary supplemental documentation.
3. We expect the insurance co-payment portion to be paid to our office within 30 -60 days.
4. If the insurance co-payment portion paid to us falls short of our original estimate, a bill for the balance due is created and mailed to the patient.
5. If the insurance co-payment portion is not paid with 60 days, a bill for the total balance due is mailed to the patient.

Authorization to perform dental treatment

I hereby authorize Dr. Brock A. Van Gordon to take radiographs, study models, photographs. or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to prescribe any and all forms of medication and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. I understand that my responsibility of payment for dental services provided in this office for me or my dependents is mine, due payable at the time services are rendered.

Signature of patient or responsible party_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
{Please 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)

Brock A. Van Gordon D.M.D., P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14,2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and, the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to obtain payment for services we provide to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare professionals include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization, you may revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with you healthcare or with payment for you healthcare, but only if you agree that we may do so.

PERSON INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your
Health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence. Counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of you health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expense such as copies and staff time. You ma also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $oo.o5 (Cents) for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will change a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed our health your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period., we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of you health information. We are not required to agree to these additional restrictions, but, if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (e-Mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jean Thorson

Telephone: 503-682-2455 Fax: 503-570-8852

E-mail: Jean@vangordon.com

Address: 30045 SW Parkway Avenue, Wilsonville, OR 97070

Van Gordon
DENTISTRY

RECORDS RELEASE FORM

I hereby authorize the release of my records to Van Gordon Dentistry.
The records I am requesting are:

* Periodontal charting and any history of SRP, including current diagnosis
* Current FMX as well as the most recent set of Bitewings
* PA's of and dates of implant placement, including brand and surgeon's name
* Chart notes for any remaining treatment needed

Patient Name:_____

Signature of Patient:_____Date:_____

Please provide the requested records to Van Gordon Dentistry within the next 14 days.

Van Gordon Dentistry
30045 SW Parkway Ave, Wilsonville OR 97070
503-682-2455
email to info@vangordon.com