Craig Family Dentistry
5840 NE Cornell Rd.
Hillsboro, OR 97124
P:503-648-3212
E:admin@craigdmd.com

Date _____

New Patient Registration

Name _____
Last First M.I.

Address _____

_____
City State Zip

Age _____ Date of Birth _____ Sex: M☐ F☐ Marital Status _____

Social Security # _____ Occupation _____

Contact Information:

Cell Phone _____ Home Phone _____

Work Phone _____ Email _____

Contact Alerts for Future Appointments:

check all that apply:

☐Text ☐Call ☐Email

Dental Insurance Information:

Employer:_____

Insurance Company:_____

Subscribers Name:_____

Subscriber ID#:_____

Policy/Group#:_____

Subscriber DOB:_____

How Did You Find Out About Our Team?

Facebook ☐ Practice Website ☐ Online Reviews ☐ Sign☐

Referred by: _____

Adult Medical History

Primary Physician:_____ Physician's Phone Number:_____

Are you currently under a doctor's care?.....☐ Yes ☐ No

If yes, please explain:_____

Have you been hospitalized or had any surgeries in the last 5 years?.....☐ Yes ☐ No

If yes, please explain:_____

Have you had any unfavorable reaction following dental treatment?.....☐ Yes ☐ No

If yes, please explain:_____

Are you Sensitive or allergic to:

☐ Penicillin	☐ Erythromycin	☐ Latex
☐ Codenine	☐ Sulfa Drugs	☐ Sedatives
☐ Tetracycline	☐ Metals	☐ Dental Anesthetics

List allergen and describe reaction:_____

Are you allergic to any other medications, drugs or treatments?.....☐ Yes ☐ No

If yes, please explain:_____

Are you taking or have you in the past twelve years, take any bisphosphonate medications?..☐ Yes ☐ No

If yes, how long:_____

please indicate which medication: ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Other

If other, please list medication:_____

Are you currently taking any prescription or non-prescription medication?.....☐ Yes ☐ No

Medication	Dose/Frequency	Reason for Taking

Do you use tobacco?.....☐ Yes ☐ No

Packs/cans per day:_____ # of years:_____

Do you use alcohol?.....☐ Yes ☐ No

How ofter?_____

Health History

Primary Physician:_____ Physician's phone Number:_____

Do you have or have had any of the following:

- ☐ AIDS/HIV
- ☐ Abnormal Bleeding
- ☐ Alcohol Addiction
- ☐ Alzheimer or Dementia
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Pins:Bones/Joints
  - When:_____
  - Where:_____
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Tumors
  - Type:_____
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
  - Type:_____
- ☐ Difficulty Breathing
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting or Dizzy Spells
- ☐ GERD or Reflux
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Attack
  - Date:_____
- ☐ Heart Disease
- ☐ Heart Surgery
  - Surgery Type:_____
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
  - Disorder:_____
- ☐ Osteoporosis
- ☐ Pacemaker
  - Date Placed:_____
  - Type Placed:_____
- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke/CVA
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other

Women Only: Are you or could you be pregnant?.....☐ Yes ☐ No Due Date:_____

Please list any serious medical condition(s) not indicated abouve you have experienced in the last 5 years

_____

_____

_____

Emergency Contact:_____ Phone:_____ Relationship:_____

By signing this form, I acknowledge the the information provided is true and accurate to the best of my knowledge.

_____ _____

Patient Signature Date

Dental History

What are your primary concerns with your dental health?

_____

_____

Have you ever had any trouble with previous dental treatment?

_____

_____

Is there a specific reason you decided to find a new dentist, or anything that we can do that will help us take care of you as best as possible?

_____

_____

_____

Do you presently have or have you had any of the following:

Bleeding/Sensitive Gums ☐

Aching or Sensitive Teeth ☐

Injuries to your face or jaw ☐

Pain or discomfort in your mouth, face, or jaw ☐

Anxiety in having dental treatment ☐

Have you noticed if you clench or grind your teeth? _____

Do you have jaw joint (TMJ) pain? _____Noise? _____Locking? _____

When was your last dental visit? _____ Last Cleaning?_____

Have you had braces (orthodontics) in the past? _____

Have you had previous deep cleanings (periodontal therapy)? _____

Reserving Time for your Dental Care

Your time is important to us! Once we have reserved time to care for you, please let us know as soon as possible if an emergency arises and you need to re-schedule your treatment with us. We want to be available to care for all our patients in a timely manner, and missed appointments result in another patient missing the opportunity to be taken care of. A $50 cancellation charge will be collected for missed appointments or cancellations less than 24 hours before your reserved time with us. We will be understanding if it is an emergency situation out of your control. We believe this is the best way to ensure that all of our patients can have necessary dental treatment taken care of as soon as possible.

Financial Arrangements

Payment for treatment is due the day treatment is provided. For your convenience, we accept all of the following payment options:

Cash
Check
Money Order
Major Credit Cards

Utilizing Dental Insurance Benefits:

If you have Dental Insurance, we will be happy to help you utilize your dental benefits by billing your insurance for you! For our office to accept assignment of benefits from your dental plan, it is important for you to understand the following:

1) Your dental plan is a contract between you and your insurance carrier. We are not a party to that contract. It is your responsibility to understand your benefits as defined by your plan.
2) You are responsible for payment of all charges for treatment. Some, if not all of your treatment may not be covered by your dental plan. You are responsible for any finance charges on any outstanding balances. Future services, both dental and clerical, may be refused until the balance is cleared.
3) If necessary, we will submit a claim for payment twice to your dental plan. However, if there is no resolution, it is your responsibility to contact their dental plan and seek payment.
4) If your dental plan has not paid the assigned balance in full by 90 days from the date the charges were incurred, you are responsible to pay for the balance of your treatment.

I have read the financial arrangements and I understand and agree to abide by this policy. I authorize my insurance carrier to assign dental benefits to this office. I also authorize the release of any information necessary to process my dental claim.

_____ _____

Signature of Patient/Responsible party **Date**

Ian Craig D.M. D.
5840 NE Cornell Rd
Hillsboro, OR 97124
503 648-3212
Fax 503 648-2864

Acknowledgment of receipt of HIPAA policies, procedures, and notice of privacy practices

Ian Craig D.M.D.

I, _____, have received and reviewed a copy of our dental practice's HIPAA policies and procedures, and a copy of our 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)

_____