



Ian Craig, DMD
5840 NE Cornell Rd.
Hillsboro, OR 97124
P: 503-648-3212 F: 503-648-2864
E:admin@craigdmd.com

This letter confirms your appointment with Craig Family Dentistry. Please complete the following forms prior to your appointment, if you are unable to fill them out prior please arrive 15 minutes early.

Important Info:

- Please bring your dental insurance card with you to your appointment.
- We ask that you fill out our Records Release Form and return prior to your visit, this allows our office with enough time to receive any imaging required for your visit.

Appointment Policy: We are aware there are situations that may arise that may result in you needing to change your appointment.

Please Note:

- Any cancelled appointments made within **24 hours** prior to your appointment will result in a **\$50 Charge.**
- No show appointments will result in a **\$50 Charge.**
- Arriving more than 15 minutes after your appointment time, may result in rescheduling your appointment.

Thank You for choosing Craig Family Dentistry for your dental care. Please reach out to our office with any questions at 503-648-3212.

Sincerely,
Craig Family Dentistry



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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

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 often? _____

Health History

Primary Physician: _____ Physician's phone Number: _____

Do you have or have had any of the following:

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

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

Please list any serious medical condition(s) not indicated above 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)
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