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 canceled appointments made within 2 4 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

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

New Patient Registration

Date _____

Name _____
_____ Last First
M.I.

Address _____

_____

City State Zip

Age:_____ Date Of Birth:_____ Marital Status:_____

Sex: Male ☐ Female ☐ Undefined ☐ Other ☐ Social Security#:_____

Contact Information:

Cell Phone _____ Home Phone _____

Work Phone _____ Email _____

Preferred Contact Alert for Future Appointments:

☐ Text ☐ Call ☐ Email

Dental Insurance Information:

Employer: _____

Insurance Company:_____

Subscriber Name:_____

Subscriber ID #:_____

Policy/Group #:_____

Subscriber ID#:_____

How Did You Hear About Our Office?

Facebook ☐ Practice Website ☐ Online Reviews ☐ Sign ☐ Other ☐

Referred by: _____

Adult Medical History

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 ☐ Codeine ☐ 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, taken any bisphosphonate medications? ☐Yes ☐ No
If yes, how long:_____

Please indicate which medication: ☐Actonel ☐ Fosamax ☐ Zometa ☐Other
If other, please list the medication:_____

Are you currently taking any prescription or non-prescription medication(s)?..... ☐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 Often?
_____

Have you ever been diagnosed with sleep apnea? Yes_____No_____

If so, do you use a CPAP machine? Yes_____No_____

Do you have or have you had one of the following:

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

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

_____

If applicable, are you or could you be pregnant? Yes ☐ No ☐ If yes, due date:_____

Emergency Contact:_____Phone:_____Relationship:_____

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

Craig Family Dentistry

Smile Questionnaire

Name:_____

Date of Birth:_____

Please circle the answer to the following questions:

How would you rate your smile out of 10? (10 being perfect)	1 2 3 4 5 6 7 8 9 10	
Is there any part of your smile you would like to change?	Yes	No
How many times per day do you brush your teeth?	1 x Per Day	2 x Per day
Do you use an electric toothbrush?	Yes	No
Do you floss or use a water pick?	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Are your teeth sensitive?	Yes	No
Would you like your teeth to be whiter?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you have any gaps in your teeth that you are unhappy with?	Yes	No
Do you have any other concerns with your teeth?	Yes	No

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:

Do you have jaw joint (TMJ) pain?... ☐Yes ☐No

Bleeding/Sensitive Gums…….☐ Yes ☐ No

Aching or Sensitive Teeth…..☐ Yes ☐ No

Injuries to your face or jaw…..☐Yes ☐ No

Pain or discomfort in your mouth, face, or jaw….☐Yes ☐No

Anxiety in having dental treatment……☐Yes ☐No

Bleeding/Sensitive Gums…….☐Yes ☐No

Aching or Sensitive Teeth……☐Yes ☐No

Do you grind your teeth……☐Yes ☐No

When was your last dental visit? _____

When was your last dental cleaning?_____

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

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

Craig Family Dentistry Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

GENERAL

Your time is important to us, once we have reserved time for your care please let us know if something arises and need to reschedule. Please see our missed appointment policy. Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENT

Any canceled appointments made within 24 hours prior to your appointment will result in a $50 Charge. We will be understanding if it is an emergency situation out of your control.

PAYMENT

If no insurance benefits apply, FULL PAYMENT is due at the time of service.

If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

FORMS OF PAYMENT

Please indicate below the payment you wish to choose.

___Cash
___ Check
___ Visa, MasterCard, Discover, AMEX

INSURANCE

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request, and billing your insurance for provided treatment. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy.

Please be aware any balance is your responsibility whether or not your insurance company pays any portion. Unpaid balance over 30 days old will be subject to monthly interest of 1.5%. If payment is delinquent, the patient will be responsible for payment of collections, associated with the recovery of the monies due on the account.

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)

_____