NEW & EXISTING PATIENT INFORMATION FORM

SUE CHADWICK WALKER DMD, FAGD
11147 SE 21ST AVE ■ MILWAUKIE, OR 97222-7696
PHONE (503) 659-2522

DATE ☐☐ / ☐☐ / ☐☐

Completion of this information in its entirety is required at time of visit

Full Legal Name : Preferred Name:

Preferred Pronouns: Date of Birth : ☐☐ / ☐☐ / ☐☐☐☐

Home Address : City: State: Zip:

Social Security Number: ☐☐☐ / ☐☐ / ☐☐☐☐ Email:

Cell Phone: ☐☐☐ / ☐☐☐ / ☐☐☐☐ Home Phone: ☐☐☐ / ☐☐☐ / ☐☐☐☐

Employer: Occupation:

Employer Address: City: State: Zip:

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner

Spouse/Parent: Social Security Number: ☐☐☐ / ☐☐ / ☐☐☐☐

Preferred Name: Date of Birth : ☐☐ / ☐☐ / ☐☐☐☐

Home Address : City: State: Zip:

Cell Phone: ☐☐☐ / ☐☐☐ / ☐☐☐☐ Email:

Employer: Occupation:

Employer Address: City: State: Zip:

If someone other than the PATIENT is responsible for payment, complete the following:

Name: Relationship to patient: Date of Birth : ☐☐ / ☐☐ / ☐☐☐☐

Home Address : City: State: Zip:

Social Security Number: ☐☐☐ / ☐☐ / ☐☐☐☐ Email:

Employer Name and Address:

In case of EMERGENCY:

Relative to contact (other than spouse): Cell Phone: ☐☐☐ / ☐☐☐ / ☐☐☐☐

Other person to contact (Not a relative): Cell Phone: ☐☐☐ / ☐☐☐ / ☐☐☐☐

How do you intend to pay? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Other

Primary Insurance (name & address): Phone: ☐☐☐ / ☐☐☐ / ☐☐☐☐

Name of Insured: Policy Number: Group Number:

Secondary Insurance (name & address): Phone: ☐☐☐ / ☐☐☐ / ☐☐☐☐

Name of Insured: Policy Number: Group Number:

Has any member of your family ever been treated in our office? ☐ No ☐ Yes Name:

Who may we thank for referring you to our office? Name:

Preferred method of contact? ☐ Text ☐ Call ☐ Email **Patient Signature:**

NEW & EXISTING PATIENT HEALTH HISTORY / FORMS

Sue Chadwick Walker, DMD, P.C.
11147 SE 21st Ave | Milwaukie, OR 97222-7696
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Medical Information

Primary Physician: _____ Physicians Phone Number: _____

Are you currently under a specialty doctor's care? _____

If yes, please describe: _____

Have you been hospitalized or had any surgeries in the last 5 years? _____

If yes, please list treatment and/or surgery: _____

If you're a new patient, when was your last dental cleaning? _____

Do you wear a nightguard?
___ Yes ___ No

Do you have issues with sleep apnea?
___ Yes ___ No

Do you use a CPAP machine?
___ Yes ___ No

Do you smoke?
___ Yes ___ No Packs per day? _____ How long? _____

Do you use chewing tobacco?
___ Yes ___ No Frequency of use? _____

Have you used chewing tobacco in the past?
___ Yes ___ No

Do you use cannabis?
___ Yes ___ No

Type of use?
___ Recreational ___ Medicinal ___ Both Frequency of use? _____

What form of cannabis do you use? _____

Do you use alcohol?
___ Yes ___ No How often? _____

Have you ever had an unfavorable reaction following dental treatment? _____

Describe reaction: _____

Are you sensitive or allergic to: ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Erythromycin ☐ Sulfa Drugs ☐ Metals ☐ Latex ☐ Sedatives ☐ Dental Anesthetics

List allergen and describe reaction: _____

Are you allergic to any other medications, drugs or treatments? _____ ☐ Other

If yes, please explain: _____

In the last five years have you taken any bisphonate medications? (used to treat osteoporosis/certain cancers) _____

If yes, how long? _____ Please indicate which medication: ☐ Actonel ☐ Fosamax ☐ Zometa

If other, please list medication: _____

Are you taking any blood thinners? _____ Blood Clot? _____ Date of Blood Clot: _____

Please indicate which medication: ☐ Warfarin/Coumadin ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Aspirin

INR check frequency _____ Date of last INR check _____ Last INR level _____

Have you ever been pre-medicated with antibiotics for dental treatment? _____

Reason for pre-medication: _____

Prescribing doctor _____ Phone # _____

Date prescribed _____ Pre-medication drug _____

Are you taking any drugs, medications, vitamins or supplements at this time? _____

Current medications you are taking:
Reason you are taking:

Signature _____

NEW & EXISTING PATIENT HEALTH HISTORY / FORMS

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Medical Conditions

Has anyone in your immediate family ever been diagnosed with any of the following? Please Check all that apply?

- ☐ Heart Disease/Heart Attack
- ☐ Stroke/CVA
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Pulmonary Diseases
- ☐ Alzheimers
- ☐ Prosthetic Joint Infection or Failure
- ☐ Adverse Pregnancy Outcomes
- ☐ Osteoporosis
- ☐ Oral Cancer

Do you have or have you experienced any of the following? Please check all that apply.

- ☐ AIDS/HIV
- ☐ Abnormal Bleeding
- ☐ Alcohol Addiction
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Pins, Bones or Joints
  - When: _____
  - What Joint: _____
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer/Tumors
  - List Type: _____
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
  - Type: _____
- ☐ Difficulty Breathing
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problem
- ☐ Heart Attack
  - Date: _____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
  - Type of surgery: _____
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ 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
- ☐ Prostate condition (see below)
  - Explain _____
- ☐ Mental Health Care
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke/CVA
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Vitamin Deficiency
- ☐ Vitamin D
- Other _____

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

_____

Required

EMERGENCY CONTACT PERSON: _____ *Relationship:* _____ *Phone:* _____

Women

Are you pregnant? _____ Due Date: _____

Are you nursing? _____

Do you plan to become pregnant? _____ If yes, timeframe: _____

Number of previous pregnancies _____ Number of miscarriages _____

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

New Signature _____

USE & DISCLOSURE OF HEALTH INFORMATION FORM

SUE CHADWICK WALKER DMD, FAGD
11147 SE 21ST AVE MILWAUKIE, OR 97222-7696
PHONE (503) 659-2522

Use and Disclosure of Health Information

Consent for use and disclosure of Health Information.
PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you consent to our use and disclosure of your protected health information in order to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. Our notice provides a description of our treatment, payment activities and healthcare operations, and all of our potential uses and disclosures of your protected health information. A copy of our notice is available on our website (suewalkerdentistry.com). We encourage you to read it carefully and completely before signing this consent form.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices; if necessary, we will issue a revised Notice of Privacy pertaining to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time, including any revisions.

Right to revoke: You will have the right to revoke this consent at any time by submitting written notice of your revocation to Sue Chadwick Walker DMD, FADG at the address listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that we may decline to treat you or decline to continue treating you if you revoke this consent.

I, _____ *, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.*

Patient's Signature: _____

Patient's Full Name: _____

Date: _____

FINANCIAL AGREEMENT FORM

SUE CHADWICK WALKER DMD, FAGD
11147 SE 21ST AVE MILWAUKIE, OR 97222-7696
PHONE (503) 659-2522

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, deserve the best possible care we can provide at a reasonable cost. With this in mind, we would like to share some information with you about our financial policy. We want you to feel comfortable with us regarding your financial and insurance matters and thereby prevent any misunderstandings. We hope you will consult with us if you have any questions regarding our service and/or fees.

NEW PATIENTS: Since the initial examination/consultation appointment is a meeting seeking a professional opinion, there is a charge for this visit. Patients without insurance are required to pay this charge at time of service. For those patients with insurance, we will forward a claim to your insurance company, but you are required to pay the estimated cost your insurance will not cover at time of service. If there is an outstanding balance after payment is received, you will be billed for the remaining balance. A guarantor social security number will be required from all patients who are not paying their entire balance at time of service.

PATIENTS WITH INSURANCE: At the time of service for procedures involving lab costs (crowns, bridges, dentures, etc.) a 100% payment is required toward the estimated charge. If there is a credit balance on your account after treatment is completed and insurance payment has been received, you will be refunded. For non-lab services, patients are required to pay their estimated out of pocket costs in full at time of service.

Many patients are under the impression that if they have insurance, it is the insurance company that owes the doctor for his services. Unfortunately, that is not the case. The insurance contract is between the patient and the insurance company; therefore, the patient is responsible for the bill, regardless of insurance coverage. We are happy to submit to your insurance for you, however, it is the responsibility of the patient (or insurance) to provide our office with the following correct information: insurance company name, address, telephone number, appropriate identification numbers, the patient's birth date and the insured birth date. Even though you may have an insurance claim pending, you will receive a monthly statement for the balance on your account. Many insurance plans state that they cover up to 50%, 80% or 100% of a procedure. Despite this statement, we have found in actuality that many plans may cover less than that depending on their established and "usual and customary" fees. The benefits paid by your plan are largely determined by how much your employer or union paid for the plan. Please be aware that some insurance companies will pay a claim percentage based on their "usual and customary" fees and not on our actual charges. We are happy to request a pre-authorization of benefits, however, this usually requires approximately 3-4 weeks to be processed by your insurance company. We are preferred providers for Delta Dental and Regence Blue Cross Blue Shield (includes HMA and LifeMap) insurance plans. If this is a concern, please discuss with our office manager prior to your appointment.

PATIENTS WITHOUT INSURANCE: Financing options are available and facilitated by our office manager. If you choose to forgo these options, charges are required to be paid in full at the time of care. An estimate will be given to you at your examination/consultation or when the appointment is scheduled.

OREGON HEALTH PLAN: Our doctor does not accept OHP. Therefore, our office is unable to bill OHP for any services.

MEDICARE: We are not Medicare providers; therefore, our office is unable to bill Medicare for any services.

DISCOUNTS: A 5% discount is offered to patients who are Senior Citizens (65+) who have no insurance and pay in full at time of service. A 5% discount is offered to all patients with no insurance who pay with cash/check in full at time of service.

CREDIT/DEBIT CARDS: Visa, Mastercard and Discover cards may be used for payment on your account. Because of the costs involved, discounts are not extended to credit card payments.

PARENTAL RESPONSIBILITY: Agreements between parents accepting or denying financial responsibility for dental/medical charges are not recognized by this office. We consider the guardian (custodial) parent to be responsible for payment of services. Young Adults (age 18 and older) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs a financial agreement. This is the case regardless of insurance benefits for which they may still be eligible.

RETURNED CHECKS: A fee of $45 will be charged for check recovery as well as additional bank fees.

ACCOUNT BALANCES: The balance on all accounts is due in full within 60 days regardless of insurance coverage or anticipated payments from other sources. In the event that payment is not made within 60 days of receipt of the services, a financial charge of 1.5% per month will be added to the account (18% per annum). Delinquent accounts assigned to a collection agency will be charged a $50 collection fee.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to my doctor. I am financially responsible for any balance due. If it becomes necessary to effect collections of any amount owed, I agree to pay for all costs and expenses including reasonable attorney fees. I also authorize the doctor to release any information required for this claim.

CANCELLATION POLICY: There is an $85 fee for broken appointments with less than 24 hours' notice.

SIGNATURE: _____ **DATE** _____

HIPPA INFORMATION FORM

SUE CHADWICK WALKER DMD, FAGD
11147 SE 21ST AVE MILWAUKIE, OR 97222-7696
PHONE (503) 659-2522

Patient Full Legal Name : _____ Date of Birth : __ / __ / ____

Patient Signature : _____ Today's Date : __ / __ / ____

As a patient, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any dental, medical or billing information with your family or friends. Please provide the names of those you would like listed as being involved in your health care. This information can be changed or revoked with your permission at any time.

I give permission for information related to my dental, medical and billing information to be discussed with:

Name: _____ Relationship: _____ Phone: ___ / ___ / ____

Name: _____ Relationship: _____ Phone: ___ / ___ / ____

Name: _____ Relationship: _____ Phone: ___ / ___ / ____

Name: _____ Relationship: _____ Phone: ___ / ___ / ____

Name: _____ Relationship: _____ Phone: ___ / ___ / ____

I understand that this might include such information as diagnosis, prognosis and treatment plans, medications, post-op instructions, appointments, billing, insurance and other information relevant to my care.

☐ I decline to have my medical information discussed with family or friends.

Sue Walker DMD, PC
DENTISTRY