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

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Date of last dental cleaning? ___________________________

Primary Physician: ___________________________________ Physician's Phone Number: ________________________________

Are you currently under a specialty doctor's care? Y/N If yes, please describe: ______________________________________

Have you been hospitalized or had any surgeries in the last five years? Y/N

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

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/vape? ☐ Yes ☐ No Packs per day? __________ How long? ______________________

Do you use chewing tobacco? Yes ☐ No ☐ Frequency of use? ____________ Past user? Yes ☐ No ☐

Do you use cannabis? Y/N

Type of use? Recreational ☐ Medicinal ☐ Both ☐ Frequency of use? ________

What form of cannabis do you use? ____

Do you use alcohol? Yes ☐ No ☐ Frequency of use? __________________________________

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? ____

Describe reaction: ____

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

If yes, how long?_______ Which medication? ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Reclast ☐ Prolia ☐ Ibandronate

If other, please list medication: ____

Are you taking any blood thinners? _________ Reason? ____

Which medication? ☐ Warfarin/Coumadin ☐ Pradaxa ☐ Xareito ☐ Eliquis ☐ Aspirin ☐ Savaysa

INR check frequency?: __________ Date of last INR check? __________ Last INR level? __________

Have you every been pre-medicated with antibiotics for dental treatment? ____

Reason for pre-medication: ____

Prescribing Doctor: _____________________________________ Phone Number: ______________________________________

Date Prescribed: _____________________________________ Pre-medication drug: _________________________________

Are you taking any drugs, medication, vitamins or supplements at this time?: _______________________________________

Please list all current medications you are taking as well as the reason you are taking them

Signature: ______________________________________ Print: ______________________________________ Date: _____________

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MEDICAL/DENTAL CONDITIONS

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

- ☐ Autoimmune Disease
- ☐ Alzheimers
- ☐ Diabetes
- ☐ Heart Disease/Heart Attack
- ☐ Oral Cancer
- ☐ Osteoporosis
- ☐ Periodontal Disease
- ☐ Prosthetic Joint Failure
- ☐ Pulmonary Diseases
- ☐ Rheumatoid Arthritis
- ☐ Stroke/CVA

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

- ☐ Abnormal Bleeding
- ☐ AIDS/HIV
- ☐ Alcohol Addiction
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Pins/Bones/Joints
  When: ____________________
  What joint? ______________
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autoimmune Disease
  Explain: ___________________
- ☐ Blood Thinners
- ☐ Blood Transfusions
- ☐ 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 Condition
  Explain: ____________
- ☐ Heart Murmur
- ☐ Heart Surgery
  Type of Surgery:
  ____
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Low Blood Pressure
- ☐ Mental Health Care
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
  Explain _______________
- ☐ Osteoporosis
- ☐ Pacemaker
  Date Placed __________
  Type Placed __________
- ☐ Persistent Cough
- ☐ Prostate Condition
  Explain ____________
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Sickle cell disease
- ☐ Sinus Trouble
- ☐ Stroke/CVA
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Vitamin Deficiency
- ☐ Other ______________

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

____

Preferred Prarmacy:

____

REQUIRED

Emergency Contact Person: ____________________________ Relationship: _______________ Phone: _________________

WOMEN

Are you pregnant? ☐ Yes ☐ No Due Date: _________________

Are you nursing? ☐ Yes ☐ No

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

Patient Signature: ____ Date: ____

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
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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 patients are required to pay 100% of their estimated out of pocket cost in full. If there is a credit balance on your account after treatment is completed and insurance payment has been received, you will be refunded.
Many patients are under the impression that if they have insurance, it is the insurance company that owes the doctor for their 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: 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. If you have any questions, please consult with our Office Manager.
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 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 ___________________________

HIPAA 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:
		/ /
		/ /
		/ /
		/ /
		/ /

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

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.

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, our legal duties, and your rights concerning your health information. We must follow the 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, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice, please contact us using the information listed on 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 a physician or other healthcare provider providing treatment 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 operations 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 disclosures permitted by your authorization while it was in effect. 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 your healthcare or with payment for your healthcare; but only if you agree that we may do so.
Persons 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 care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of 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, 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 authorized 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).
YOUR HEALTH INFORMATION RIGHTS
Access: You have the right to look at or get copies of your 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, 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 your 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, and provide satisfactory explanation how payments will be handled under 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 website 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 at the address or phone number provided on this website. If you are concerned that we may have violated your privacy rights, 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 on this website. 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.

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