welcome

Please take a moment to fill out important background information.

Date: ____________________

You

Name: ____________________

Preferred Name: ____________________

Birthdate: __________ Age: _____ SSN: __________

Drivers License #: ____________________

Home Address: ____________________

____

Hm #: __________ Cell #: __________

Wk #: __________ Ext #: __________

E-mail Address: ____________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer: ____________________

Employer's Address: ____________________

____

How long? __________ Occupation: __________

When/Where are best times to reach you? ____________________

____

Other family members seen by us: ____________________

____

Spouse

Name: ____________________

Birthdate: __________ SSN: __________

DL #: __________ Cell #: __________

Wk #: __________ Ext #: __________

Employer: ____________________

Account

Person Responsible for Account: ____________________

____

Hm #: __________ Cell #: __________

Wk #: __________ Ext #: __________

Billing Address: ____________________

____

Relation: ____________________

SSN: __________ DL #: __________

Employer: ____________________

Insurance

Primary Insurance

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

____

Insurance Co. Phone #: ____________________

Group # (Plan, Local or Policy #): ____________________

Insured Name: __________ Birthdate: __________

Relation: __________ ID #: __________

Insured's Employer: ____________________

Insured's Employer's Address: ____________________

____

Insured's Employer's Phone #: ____________________

Secondary Insurance

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

____

Insurance Co. Phone #: ____________________

Group # (Plan, Local or Policy #): ____________________

Insured Name: __________ Birthdate: __________

Relation: __________ ID #: __________

Insured's Employer: ____________________

Insured's Employer's Address: ____________________

____

Insured's Employer's Phone #: ____________________

Emergency

In the event of an emergency, is there someone who lives near you that we should contact?

Name: ____________________

Relationship: ____________________

Hm #: __________ Cell #: __________

Wk #: __________ Ext #: __________

Releases

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. **Payment is due in full at the time of treatment unless prior arrangements have been approved.**

Signature: ____________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

Signature: ____________________

Name:

History

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer / Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

____

____

____

____

Have you ever taken Fosamax or any other bisphosphonate? Yes No

Have you ever taken Phen-fen? Yes No

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics
Y	N	Codeine	Y	N	Jewelry
Y	N	Erythromycin	Y	N	Latex
Y	N	Penicillin	Y	N	Metals
Y	N	Tetracycline			

Please list any other drugs / materials that you are allergic to: _____________

____

Updates

Date: __________	Patient's Initials: ________	Staff Initials: ________
Date: __________	Patient's Initials: ________	Staff Initials: ________
Date: __________	Patient's Initials: ________	Staff Initials: ________
Date: __________	Patient's Initials: ________	Staff Initials: ________
Date: __________	Patient's Initials: ________	Staff Initials: ________
Date: __________	Patient's Initials: ________	Staff Initials: ________
Date: __________	Patient's Initials: ________	Staff Initials: ________

Dental

Why have you come to the dentist today? ______________________

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Do your gums ever bleed? Yes No

Ever had serious / difficult problem(s) with previous dental work? Yes No

Your current dental health is: good fair poor

Do you like your smile? Yes No

Would you like whiter teeth? Yes No

Medical

Physician's Name: ______________________________

Phone #: ______________________ Date of last visit: ________

Your current physical health is: good fair poor

Are you currently under the care of a physician(s)? Yes No

Please explain: ______________________________

____

Are you taking any prescription / over the counter drugs? Yes No

Please list each one: ______________________________

____

____

____

____

____

____

____

____

For women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No (if yes, week number _______)

Are you nursing? Yes No

Tracking

Whom may we thank for referring you to our office? Tracking new patients is one of the ways that helps us manage our practice. Please check ONE way that best describes how you heard or were referred to our office.

People

- ☐ Previous Patient
- ☐ Family ______________
- ☐ Friend ______________
- ☐ Professional ___________

Phone Book (choose one)

- ☐ Camas/Washougal
- ☐ Dex
- ☐ Superpages

Online

- ☐ Dex
- ☐ Superpages
- ☐ Dr. Messinger's Website
- ☐ Insurance Website
- ☐ Other: ______________

Signage

- ☐ Lighted sign on the street
- ☐ Banner

Eric P. Messinger, DDS, PS
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Office Policies

OUR PHILOSOPHY - PREVENTION: We are committed to the concept of optimum dental health. You will find that prevention is the cornerstone of our practice and the foundation for maintaining healthy teeth and gums. Preventing problems before they occur is by far the most convenient and economical way to maintain good oral health. We hope that our commitment will spark in you this same initiative and enthusiasm to maintain a healthy and glowing smile.

THE INVESTMENT necessary to complete your treatment is based on an estimate derived from our examination. Should additional unforeseen problems arise as treatment progresses, this estimate may have to be revised. You will be consulted before any unexpected treatment is undertaken. This estimate will be honored provided treatment is completed within six (6) months of the date of the initial examination. Payment is due at time of service. All balances, excluding expected insurance payments, over 45 days are subject to finance charge of 1.5%.

APPOINTMENTS: To give you the best and most efficient care we must work with an appointment system. We plan very carefully to reserve the right amount of time for each patient so that the most dental care can be accomplished in the fewest number of visits. With patients' best interest in mind, appointments will be scheduled at times best suited for the treatment involved.

Except in emergency situations, you may expect us to be on time, and we would appreciate the same courtesy from you. Your appointment time has been reserved exclusively for you, and any change affects many other patients. Should it be necessary for you to reschedule an appointment, we require a **minimum 24 hours** notice to avoid a broken appointment fee. There will be a minimum charge of $25.00 per half hour missed.

CHECKS RETURNED: You will be charged **$30.00** for each check that is returned by the bank.

STERILIZATION TECHNIQUES: We heat sterilize our hand pieces and equipment and use as many disposable items as possible. We consistently monitor our office to exceed OSHA and Center for Disease Control requirements.

ABOUT YOUR RECORDS: We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Insurance: Our office understands the value of insurance benefits to our patients. We will fill out and file your insurance forms at no charge. We will **estimate** your deductible and the portion that we feel will be covered by your insurance carrier. The amount that we estimate NOT covered by the insurance is due at the time of treatment. **Your insurance does not guarantee payment, therefore, payment for dental services are due regardless of the benefits paid by your insurance and is the patient's responsibility.**

Payment Options: Personal check or cash (if no insurance, receive 5% discount when paid in full at the time of service)
VISA, MasterCard or DiscoverCard
Outside Financing with interest free options available

WE ARE HERE TO HELP YOU: No question is too small for you to ask us, whether it is regarding your treatment, insurance or billing. We ask that you call or come by any time you have a question.

ASSIGNMENT OF DENTAL INSURANCE BENEFITS:

I hereby authorize payment of benefits owed by my insurance company to **Eric P. Messinger, DDS, PS** for these services. I understand the insurance company is responsible to the patient and the patient is responsible to the doctor. These services are rendered to a person not an insurance company and the person is responsible in full for the treatment rendered.

Signature of policy holder: ______________________________ Date: __________

I have read and fully understand the policies of this office. Failure to sign this policy in no way negates the patient's financial responsibility for any services that will be rendered as submission to treatment implies consent.

Responsible Party **Signature** ______________________________ Date: __________

Eric P. Messinger, DDS, PS
2016 NE 3rd Avenue ● Camas, WA 98607

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ____________________________, have received a copy of this office's Notice of Privacy Practices.

____
(Please 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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