



LAKE GROVE DENTAL

PATIENT INFORMATION

Name _____ [] Dr. [] Mr. [] Mrs. [] Ms. [] Rev. [] Other _____
Full Legal Name

Preferred Name _____ E-mail _____

Gender: _____ Preferred Pronouns: _____ Birthdate _____ SSN# _____

Address _____ Occupation _____

City _____ ST _____ Zip _____ Mobile # _____

Employer _____ Home or Other Phone # _____

Are you: [] Minor [] Married [] Single [] Divorced [] Widowed [] Separated [] Other _____

Emergency Contact Name _____ Relationship _____ Phone# _____

RESPONSIBLE PARTY (Only complete if different than the patient above) Relationship to patient: _____

Name _____ Address _____
First MI Last

Email _____ City _____ ST _____ Zip _____

Mobile Phone# _____ Wk# _____ Birthdate _____ SSN# _____

Responsible Party Signature: _____

(PLEASE SKIP SECTIONS A-C IF YOU DO NOT HAVE DENTAL BENEFITS)

DENTAL BENEFITS INFORMATION: As a courtesy to our patients, we bill your dental benefits carriers directly. It is your responsibility to understand your coverage, maximum, and exclusions. We will go out of our way to help you know what you have at your request. Your insurance is a contract between you and your insurance company. Benefits are frequently based on your insurance's contract and may not reflect on your best treatment options.

A. STUDENTS WITH BENEFITS: Status: [] Full-time [] Part-time School Name & City _____

B. DENTAL BENEFITS (A photocopy of your card may suffice)

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Policy ID# _____ Employer _____

Insurance Co. Name _____ Ins. Co. Address _____

City _____ ST _____ Zip _____ Group # _____ Eff. Date _____

C. SECONDARY DENTAL BENEFITS? [] Yes [] No If yes, please complete the following:

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Policy ID# _____ Employer _____

Insurance Co. Name _____ Ins. Co. Address _____

City _____ ST _____ Zip _____ Group# _____ Eff. Date _____

Caring for More Than Just Your Teeth

Good oral health benefits your whole-health



Dental Health History Form—Giving us a complete picture of your previous dental care and medical information helps us provide you with more complete care. Your oral health is linked to your total health, and you deserve the best. All of us at Lake Grove Dental want to make sure you receive it!

Patient Name: First _____ MI _____ Last _____ Nickname _____

Tell us how you heard about us: _____ Reason

for Visit: ☐ Broken tooth ☐ Check-up/Cleaning ☐ Cosmetic ☐ Tooth Pain ☐ Second Opinion ☐ Dentures

☐ Implant ☐ Other _____

What has your past experience with dentistry been like? _____

Approximately, when was your last continuing care visit (cleaning or periodontal cleaning) _____

Are you experiencing dental pain now? Yes ___ No ___ If yes, describe _____

Have you ever been pre-medicated for dental treatment? Yes ___ No ___ If so, what for? _____

If you are anxious about dental treatment or have worries about your oral health or smile, please don't hesitate to share them with us. We want you to be comfortable and address any concerns you may have.

Please check any of the boxes below that you are concerned about or apply to you:

- | | | |
|--|--|--|
| ☐ Swollen/bleeding gums | ☐ Bite feels off | ☐ You had orthodontia in the past |
| ☐ Mouth Sores | ☐ Old fillings (gold or silver) | ☐ You currently wear a permanent retainer |
| ☐ Clenching or grinding | ☐ Old crowns | ☐ You wear removeable dental devices |
| ☐ Discolored teeth | ☐ Speech problems | ☐ You currently wear a snore device |
| ☐ Crowding/crooked teeth | ☐ Too much gum tissue showing | ☐ You use a C-pap machine |
| ☐ Missing teeth | ☐ Gums receding | ☐ You have had gum surgery or deep cleanings. If so when? _____ |
| ☐ Spaces in-between teeth | ☐ Tooth sensitivity | ☐ Other, describe _____ |
| ☐ Loose tooth/teeth | ☐ Food gets caught in teeth | _____ |
| ☐ Tooth shape/size | ☐ Bleeding when you floss/brush | _____ |
| ☐ Unhappy w/look of teeth | ☐ Difficulty chewing | _____ |
| ☐ Overbite | ☐ Bad breath | |
| ☐ Underbite | ☐ Wear an occlusal guard at night | |

Check any topics you are interested in learning about:

- | | | |
|---|--|--|
| ☐ Teeth whitening | ☐ Tooth-colored fillings | ☐ In-house Loyalty Plan for the uninsured |
| ☐ Orthodontic treatment | ☐ Dental Implants | ☐ Other, describe _____ |
| ☐ Veneers | ☐ Preventing periodontal disease | _____ |
| ☐ Dental care during pregnancy | ☐ Oral hygiene for infants and/or seniors | _____ |

Patient (or Guardian's) Signature _____ **Today's Date** _____

MEDICAL INFORMATION

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for checking off the items that apply to you.

Cardiovascular

- ☐ A-Fib
- ☐ Heart Valve Replaced
- ☐ Coronary Artery Disease
- ☐ Chest Pain or Angina
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Stent Installed
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Stroke/TIA Date: _____
- ☐ Tachycardia

Endocrine

- ☐ Diabetes
- ☐ Pre-Diabetic
- ☐ Gout
- ☐ Hormonal Change
- ☐ Thyroid problems

Eyes, Ears, Nose and Throat

- ☐ Change in Hearing
- ☐ Change in Vision
- ☐ Ear Pain
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Nasal Obstruction
- ☐ Nose Bleeding
- ☐ Sinus Problems
- ☐ Tinnitus (Ringing)

Gastrointestinal

- ☐ Acid Reflux
- ☐ GERD
- ☐ Ulcers

Genitourinary

- ☐ Frequent Urination
- ☐ Kidney disease
- ☐ Nocturia
- ☐ Dialysis

General

- ☐ Cancer, if yes describe _____
- ☐ In Cancer Treatment Now
Describe: _____
- ☐ General Weakness
- ☐ Fatigue/Tired
- ☐ Headaches/Migraines
- ☐ HIV/AIDS/STD List: _____

- ☐ Knee/hip replacement
- ☐ Liver Disease/Problems
- ☐ Recent Trauma or Injury
- ☐ Rheumatic Fever
- ☐ Radiation Treatment
- ☐ Unexplained Weight Change
- ☐ Swollen ankles
- ☐ Organ Transplant - List: _____

Hematological

- ☐ Anemic
- ☐ Bleeding problems
- ☐ Bruise Easily
- ☐ Hepatitis Type _____
- ☐ Last A1C score _____

Oral

- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Sjogren's Syndrome
- ☐ Jaw Problems (TMJ)
- ☐ Jaw Clicking
- ☐ Jaw Pain
- ☐ Difficulty Swallowing
- ☐ Difficulty Chewing
- ☐ Has Had Orthodontics
- ☐ Periodontal Disease
- ☐ Teeth Clenching
- ☐ Teeth Grinding
- ☐ Tooth Pain
- ☐ Wisdom Tooth Extraction
- ☐ Removable Teeth
- ☐ Wears a nightguard
- ☐ Wear Ortho Retainer(s)
- ☐ Cold or Canker Sores

Musculoskeletal

- ☐ Artificial Joint
- ☐ Arthritis
- ☐ Back Pain
- ☐ Fibromyalgia
- ☐ Joint Pain
- ☐ Osteopenia
- ☐ Orthopnea (Can't Lay Flat)
- ☐ Osteoporosis
- ☐ Spinal Surgery

Neurological

- ☐ Alzheimer's Disease
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Memory Loss
- ☐ Multiple Sclerosis (MS)
- ☐ Muscle Weakness
- ☐ Seizures

- ☐ Tingling/Numbness
- ☐ Trigeminal Neuralgia
- ☐ Tremor

Psychiatric

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Autism
- ☐ Eating Disorders
- ☐ Excessive Stress
- ☐ Memory Problems
- ☐ Dental Phobia

Respiratory

- ☐ Asthma
- ☐ Breathing Problems
- ☐ Chest Pressure
- ☐ COPD/Emphysema
- ☐ Congestion
- ☐ Dyspnea (shortness of breath)
- ☐ Pulmonary Embolism
- ☐ Tuberculosis

Sleep

- ☐ Daytime Sleepiness
- ☐ Morning headaches
- ☐ Others say you snore
- ☐ Sleep Study Done - Results:
 - ☐ Mild
 - ☐ Mod
 - ☐ Severe
 - ☐ No Apnea
- ☐ Obstructive Sleep Apnea
- ☐ Do you use a CPAP?
If so, how often? _____
- ☐ Wear oral device for sleep apnea?

Habits

- ☐ Alcohol
 - ☐ Less than 1/day
 - ☐ More than 1/day
- ☐ Smoke or Chew currently
Qty: _____
- ☐ Former Smoker, when quit
Year: _____
- ☐ Vape currently
- ☐ Recreational Drugs
- ☐ Special Diet

ANY Other Not Listed:

Medical History, continued

This information will not be shared without the express authorization of the patient. Updates are required every two years or when there are significant health changes.

In a few words, describe how good you think your health is _____

Has there been a change in your health or the medications you take in the last two years? Please describe: _____

Have you gone to the hospital or had a serious illness in the last two years? Why/what? _____

Are you being treated by a physician now? Yes ____ No ____ If yes, for what? _____

When was your last physical? _____ Physician's Name/City _____

Your current weight? _____ Your height? _____ Women: Are you or could you be pregnant? Due Date _____

Do you have any pain in your body now? Yes ____ No ____ If yes, describe _____

Do you currently need to be premedicated for dental treatment? Yes ____ No ____ If so, for what? _____

Emergency contact: Name _____ Relationship _____ Phone _____

Allergies: Are you allergic to or had a reaction to:

☐ Local anesthetic

☐ Foods- Describe _____

☐ Penicillin

☐ Other Antibiotics _____

☐ Sulfa drugs

☐ Metal(s)- Describe _____

☐ Tranquilizers/Sedatives

☐ Aspirin _____

☐ Codeine or other narcotics

☐ Latex

☐ Other - Please list any

Have you ever experienced anaphylaxis? Yes ____ No ____ If so, what triggered the episode? _____

Medication Information

Are you currently, or have you taken in the past, medications for bone density? Yes ____ No ____

Please list all medications and supplements (vitamins) you are currently taking or provide a printed list: _____

I certify that I have read and understand the entire medical and dental history forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist and his staff of any changes in my health and/or medications. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of these forms.

Signature of Patient (or Guardian) _____ Date _____

Signature of Healthcare Provider _____ Date _____

Office Policies

Consent to Treatment

I voluntarily consent to and authorize the dental professionals at this practice to perform examinations, X-rays, cleanings, and any other dental procedures deemed necessary for my dental health. I understand that:

- Dental care involves certain inherent risks, including but not limited to infection, swelling, discomfort, and temporary or permanent changes in sensation.
- No guarantee of specific results has been made or implied. Results depend on individual health factors beyond the practice's control.
- I have the right to refuse any recommended treatment and will be informed of alternative options and the consequences of non-treatment.
- Additional procedures may be required during treatment that were not identified during the initial examination.
- Radiographs (X-rays) may be required for diagnosis and to ensure safe treatment.

Financial Policy & Payment Agreement

I understand and agree to the following financial terms:

- Payment is due at the time of service unless prior arrangements have been made with the billing department.
- I am responsible for all fees associated with my dental care, regardless of insurance coverage.
- Insurance claims will be submitted on my behalf as a courtesy; however, unpaid balances remain my responsibility.
- Accounts with balances outstanding beyond 90 days may be referred to a collections agency, and I will be responsible for any associated collection costs.
- A fee may be charged for returned checks or declined payments.
- Finance charges may be applied to balances not paid within the agreed timeframe.

Cancellation & Appointment Policy

To ensure availability for all patients, I agree to the following appointment policies:

- I will provide at least 48 hours' advance notice if I need to cancel or reschedule an appointment.
- Appointments cancelled with less than 48 hours' notice, or missed without notice, may be subject to a cancellation fee.
- Repeated late cancellations or no-shows may result in the requirement of a deposit for future appointments or discharge from the practice.

Medical History & Disclosure

I confirm that the medical history information I have provided is accurate and complete to the best of my knowledge. I understand that:

- It is my responsibility to inform the dental team of any changes to my health, medications, or allergies at each visit.
- Failure to disclose relevant medical information may affect the safety and effectiveness of my dental care.
- I must disclose all medications, supplements, and over-the-counter drugs I am currently taking.
- I must inform the practice of any known allergies, including allergies to medications, latex, or materials.

Sometimes patients wish their information to be shared w/other designated person(s). This info may be revised at any time. Please complete the following and mark what info may be shared and with whom.

Name: _____ Relationship: _____ Medical: Y N Financial: Y N

By signing below, I agree to Lake Grove Dental's Policies shown above:

Patient Name _____ Date of Birth _____ Today's Date _____

Patient Signature _____ or Guardian's Signature _____

Notice of Privacy Practices

A Notice to Our Patients Regarding Our Privacy Policy and Information Practices

The Doctors and Staff of Lake Grove Dental are fully committed to protecting the confidentiality of your personal, financial, and health information, as directed under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") and your Protect Health Information ("PHI"). State and Federal law requires us to inform you of our policy and practices while we are providing services to you. In the event of a data breach, all patients affected would be contacted and a notice on our website posted.

How We Protect Your Information: We authorize individuals to access your personal information only to the extent necessary to conduct our business and serve you, such as when making and confirming dental appointments, submitting insurance claims, securing insurance benefit information, and submitting applications for third-party payment arrangements per your request. We take steps to secure our building, patient files, and electronic systems from unauthorized access. Our employees are trained regarding confidentiality and held to strict Office Policy and Procedures regarding your personal and health information, both written and verbal. All employees are subject to disciplinary action for violation of any of these policies and procedures. Information we may collect are name, Social Security Number, address, telephone number, employment, medical history, health records, claims information, and drivers license number.

Why We May Share Information: We may share your personal or health information with third parties in the course of normal business functions, with or without your prior authorization. Examples of such business functions include:

- Submission of dental claims
- Referrals to specialists
- Requests from other health care providers
- Requests to or from pharmacies
- Processing transactions you request
- Appointment notification via postcards, voice messages, email, or other written and verbal means
- Persons that you have specified and directed us to communicate with on the Privacy Policy Consent form

Once the information leaves our office: We no longer have control over how it will be used by the recipient. Other health care providers, health care insurance agencies and dental/medical laboratories will have the same stringent rules about HIPAA and PHI as we do, but if you have authorized us to share with individuals or agencies outside of the scope described you may no longer be protected by these rules.

Your Patient Rights: We gladly honor your right to request access to your personal information. To do so, you must submit a written request describing the information being requested. In rare cases, there may be a charge of \$.10 per page, or \$25.00 per hour of staff time, plus postage, to retrieve, copy and send the requested information. If we are able to locate and retrieve the information requested, within 30 days of your request we will:

- Inform you in writing or by telephone of the nature and substance of the personal information gathered.
- Permit you to see and copy that information in person, or to obtain a copy by mail at your preference.
- Disclose the persons with whom we've shared your personal information within the last 6 years (from the date you last signed our Notice of Privacy Acknowledgment Form), or if unavailable, the names of the organizations or persons to whom the information is normally disclosed.
- Provide a summary of the procedures by which you may request correction, amendment or deletion of personal info.

If you request correction, amendment or deletion of personal information, we will either comply with your request or notify you of our reasons for refusing to do so. You may then submit a statement telling us what you believe to be relevant and fair information, and the reasons you disagree with our decision. Your statements will then be filed with your personal information.

SMS Communications Disclosure

Terms and Conditions (Terms of Service) -By opting in to receive SMS messages from Lake Grove Dental, you agree to the following terms:

By providing my phone number, I consent to receive SMS text messages from Lake Grove Dental for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg & data rates may apply. Reply HELP for support. Reply STOP to opt out.

- **Message Frequency** - You will receive up to 4 messages per month.
- **Message and Data Rates** - Rates may apply based on your mobile carrier's terms.
- **Privacy Policy** - Your information will be handled in accordance with our Privacy Policy, which can be viewed below.
- **Opt-Out Instructions** - You can opt out at any time by replying "STOP" to any SMS message. Reply HELP for support. You may also contact us directly at ph. 503.636.3641 or info@lakegrovedental.com
- **Liability** - We are not responsible for any charges, errors, or delays in SMS delivery caused by your carrier or third-party service providers. By opting in, you confirm that you are the owner or authorized user of the phone number provided and that you are at least 18 years old.

Patient Signature _____ Patient Name: _____ Date _____



LAKE GROVE DENTAL
PROGRESSIVE DENTAL CARE SINCE 1960

Authorization for Dental Records Release

Patient Information

Patient's Legal Name: _____ Date of Birth: _____
Email: _____ Mobile Ph: _____

Authorization

I request and authorize (doctor or clinic name) _____ to release health and dental care information for the above-named patient to: Charles Branen, DMD, PC (d.b.a. Lake Grove Dental)

Please transfer any the following records applicable:

Panorex, CBCT or Full Mouth X-rays that are under 5 years

Bitewing X-rays under 1 year

Dates & quadrants scaling & root planning were performed

Most recent periodontal charting

Date & type of most recent dental cleaning

A copy of this release will be as effective and valid as the original form. This request and authorization is valid for one year from the date it is signed.

If no images are being sent, please return above information via fax to 503.636.3641

Images and any other info may be emailed to info@lakegrovedental.com

Patient Signature: _____ Date signed: _____

OR Signature of legal Guardian/Parent if a child is under 18 years: _____

4055 Mercantile Dr., Suite 105 | Lake Oswego, OR 97035
Phone/FAX/Text: 503.636.3641 | info@lakegrovedental.com | www.lakegrovedental.com