NEWPORT OREGON

DOUG CHADWICK DDS

FAMILY DENTIST

On behalf of the entire staff at Dr. Chadwick's office, welcome! We are delighted that you've decided to trust us with your dental needs. Dr. Chadwick and our wonderful team strive to provide each patient with the highest quality dental care, in a gentle and personal manner. Understanding each patient is unique, we take time to understand your needs, providing an individualized plan for attaining and maintaining optimal oral health. Building your trust through effective communication is imperative. We always want you to feel completely comfortable with the dental treatment recommended or dental work you are about to undergo. We will present a thorough explanation of the procedure and are happy to address any concerns you may have.

On the day of your initial appointment, please bring your completed new patient forms along with any current dental insurance information and photo ID.

In the meantime, if you have any concerns or questions, please feel free to call us at **541-265-4221** or email our Patient Care Coordinator at whitney@dougchadwickdds.com. We look forward to meeting you soon!

123 SE DOUGLAS STREET NEWPORT, OR 97365

EMAIL INFO@DOUGCHADWICKDDS.COM | PHONE (541) 265-4221 | WEBSITE WWW.DOUGCHADWICKDDS.COM

Douglas A. Chadwick, DDS

General & Family Dentistry
123 SE Douglas St., Newport, Oregon 97365
(541) 265-4221

Patient's full name _____ Birthdate ____ / ____ / ____

Mailing address _____ Home Ph # _____

_____ Work Ph # _____

Patients Social Security # _____ Cell Ph# _____

Name of spouse/parent/guardian _____ E-Mail _____
(circle one)

Previous dentist _____ Last treatment ____ / ____
Name City Mo. Yr.

Whom may we thank for referring you to us? _____

PERSON RESPONSIBLE FOR ACCOUNT

_____
Name Address City PH#

Soc. Sec. No. _____ Employer _____

Years with employer _____ Work Ph # _____ Drivers License # _____

(THERE IS A 15% APR FINANCE CHARGE ON ACCOUNTS 30 DAYS PAST DUE)

Date _____ Signed _____

EMERGENCY NOTIFICATION

Name _____ Ph. # _____ Relationship _____

FOR PATIENTS WITH DENTAL INSURANCE

Insured person's name _____ Soc. Sec. No. _____

Insured date of birth ____ / ____ / ____

Insurance company & Employer: _____ Group/Policy # _____

Coverage is for: ❑ Self ❑ Spouse ❑ Dependents

If a second dental insurance policy exists, please complete the following —

Insured person's name _____ Soc. Sec. No. _____

Insured date of birth ____ / ____ / ____

Insurance company & Employer: _____ Group/Policy # _____

Coverage is for: ❑ Self ❑ Spouse ❑ Dependents

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies.

This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled.

Date _____ Signed _____

DOUGLAS A. CHADWICK, DDS

MEDICAL HISTORY

Patient Name_____ Nickname _____ Age_____
Name of Physician/and their specialty_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
hospitalization for illness or injury_____	☐	☐
an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver _____)		
☐ latex		
☐ other_____		
heart problems, or cardiac stent within the last six months ___	☐	☐
history of infective endocarditis_____	☐	☐
artificial heart valve, repaired heart defect (PFO)_____	☐	☐
pacemaker or implantable defibrillator _____	☐	☐
artificial prosthesis (heart valve or joints) _____	☐	☐
rheumatic or scarlet fever_____	☐	☐
high or low blood pressure _____	☐	☐
a stroke (taking blood thinners) _____	☐	☐
anemia or other blood disorder_____	☐	☐
prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
emphysema, sarcoidosis _____	☐	☐
tuberculosis_____	☐	☐
asthma _____	☐	☐
breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
kidney disease _____	☐	☐
liver disease _____	☐	☐
jaundice _____	☐	☐
thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
hormone deficiency_____	☐	☐
high cholesterol or taking statin drugs _____	☐	☐
diabetes (HbA1c =) _____	☐	☐
digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
arthritis _____	☐	☐
glaucoma _____	☐	☐
head or neck injuries_____	☐	☐
epilepsy, convulsions (seizures) _____	☐	☐
neurologic problems (attention deficit disorder) _____	☐	☐
viral infections and cold sores_____	☐	☐
any lumps or swelling in the mouth_____	☐	☐
hives, skin rash, hay fever _____	☐	☐
hepatitis (type _) _____	☐	☐
HIV/AIDS _____	☐	☐
tumor, abnormal growth _____	☐	☐
radiation therapy_____	☐	☐
chemotherapy_____	☐	☐
emotional problems _____	☐	☐
psychiatric treatment_____	☐	☐
antidepressant medication _____	☐	☐
street drug use _____	☐	☐

ARE YOU:		
presently being treated for any other illness_____	☐	☐
aware of a change in your health (i.e. fever, new cough _____	☐	☐
taking medication for weight management (i.e. fen-phen) ____	☐	☐
taking dietary supplements_____	☐	☐
often exhausted or fatigued _____	☐	☐
experiencing frequent headaches_____	☐	☐
a smoker smoked previously or use smokeless tobacco _____	☐	☐
FEMALE- taking birth control pills_____	☐	☐
FEMALE- pregnant_____	☐	☐
MALE -prostate disorders_____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications or supplements

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ **Date**_____

Doctor's Signature _____ **Date**_____

No Changes: Date_____ **Date** _____ **Date**_____ ○ ○ ○

Financial Policy

Thank you for choosing Doug Chadwick, DDS. We believe in giving you the best possible dental care and want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan as well as our financial policy.

Do You Accept My Insurance? How Much Will They Pay?

We currently work with most private dental benefit plans. We will bill your insurance company as a courtesy to you, however the responsibility for payment remains with you. Coverage may be limited by what the insurance company calls the "usual, customary, and reasonable" (UCR) fees. These are ceilings on the fees for dental procedures, set by the insurance company, at which the benefit plan will stop reimbursement. There may be differences between our fees and the UCR fees because the UCR fees were often determined many years ago, and are seldom relevant to quality dentistry in today's market. Any differences between the two fees are the responsibility of you, the patient.

Although we maintain computerized histories of payment by several companies, payment of benefits is never guaranteed by insurance companies. Therefore, it is impossible to give you a guaranteed quote prior to or at the time of service, even if the service is preauthorized. We estimate your portion based on the most up-to-date information we have, but it is still *only an estimate.*

My Insurance Did Not Pay- Now What?

Please keep in mind that a dental benefit plan is a contract between you, the patient, your employer, and the insurance company. Therefore, you are ultimately responsible for all charges regardless of the benefits.

Financial Options

Payment is due at the time of service.

We accept cash, checks, and credit cards. We also offer extended pay options, pending your approval, through third party dental care financing companies.

Finance Charges

All past due balances are subject to finance charges of 15% APR. This is to offset the costs associates with repeated billing statements.

I understand that I am responsible for all costs of dental treatment. I have read and fully understand that financial policies of this dental office.

Signed: _____ Date: _____

Patient, Parent, or Guardian

Printed: _____

Printed Name

Douglas A. Chadwick, DDS
General & Family Dentistry
123 S.E. Douglas St.
Newport, OR 97365
(541) 265-4221

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 and Date)

Permission to Disclose Health Information

DOUGLAS A. CHADWICK, DDS
Name of Practice

We may disclose your health information to a family member, personal representative, 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. Please list the individuals below who have your permission to share your health information:

Name	Relationship to Patient	Conditions of Access

SIGNATURE

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 health care operations.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient: _____

NEWPORT OREGON
DOUG CHADWICK DDS
FAMILY DENTIST

Records Release Authorization

To:
Dentist Name _____
Address _____
City, State _____Zip_____
Phone _____
FAX _____
Email _____

I hereby authorize the release of any or all portions of my dental records to be sent to:
Dr. Doug Chadwick, DDS
123 SE Douglas ST.
Newport, OR 97365
Phone 541-265-4221 FAX 541-205-7629
Email records to: whitney@dougchadwickdds.com

****PLEASE SEND FMX AS SEPARATE IMAGE****

Please include any information that may help in my dental treatment.
If there is a fee for this service, please call our office.

Please send the following items:
Daily Records/Chart Notes
Any Pano or FMX within 10 years
Most recent BWXs
Periodontal Charting

If there are any questions regarding transferring records, please give our office a call, or refer to the Oregon Board of Dentistry rules. Thank you for your assistance.

Date _____

Patient Name (print) _____

Patient or Parent/Guardian Signature _____

Relationship to Patient _____