CARRIE B. LAIRD, DMD
LISA S. STRAUCH, DMD

Last Name First Name MI Preferred Referred By

Male/Female Child Single Married Divorced

DOB Age Social Security Number

Mailing Address City State Zip

Home Phone Cell Phone Work Phone

Employer/Employer Address Occupation

Spouses Name Do you have children? How many?

Emergency Contact
Whom should we contact?

Relation Phone Number

Who is your Medical Doctor? Phone Number

Account Information
(Person ultimately responsible for account)
Name Relation

Billing Address Phone Number

Social Security Number

Dental Insurance Information
Primary Dental Insurance:

Dental Insurance Company

Customer Service Number Insured ID No. Group No.

Insured's Name Relation DOB

Insured's Employer/Address

Secondary Dental Insurance:

Dental Insurance Company

Customer Service Number Insured ID No. Group No.

Insured's Name Relation DOB

Insured's Employer/Address

Dental Information

Reason for today's visit? Exam Emergency Consultation

Are you in pain? Yes No **How Long?**____________________

Please indicate any of the following problems:

Y N Discomfort, clicking or popping in jaw
Y N Lost/Broken Filling(s)
Y N Stained Teeth
Y N Red, swollen or bleeding gums
Y N Teeth Grinding
Y N Locking Jaw
Y N Sensitive tooth, teeth or gums
Y N Ringing in Ears
Y N Bad breath
Y N Blisters/Sores in or around mouth
Y N Broken/Chipped tooth

Other____________________

Do you required pre-medication? Yes No Don't know

Previous Dentist:____________________

Name Phone Number

Last Dental exam:____________________ Last Dental X-rays:____________________

Times a day you brush?____________________ **How often do you floss/clean between teeth?** ____________________

What type of tooth brush bristles do you use? Soft Medium Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical History

What medications are you currently taking? (prescriptions, over the counter, and natural remedies/vitamins)

Please list all:____________________

____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) Yes No Phen-fen/Redux Yes No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke
Y N Heart Surg/Pacemaker
Y N Heart Murmur
Y N Rheumatic fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Defect
Y N Chest Pains
Y N Scarlet Fever
Y N Nervousness
Y N Thyroid Problems
Y N Kidney Problems
Y N Liver Problems
Y N Respitatory problems
Y N Sinus Problems
Y N Stomach problems/Ulcers
Y N Psychiatric Problems
Y N Venereal Disease
Y N Alcohol/Drug Abuse
Y N Tuberculosis TB
Y N Jaw Problems TMJ/TMD
Y N Cancer/Tumors
Y N Shingles
Y N Hepatitis
Y N HIV+/AIDS/ARC
Y N Arthritis/Rheumatism
Y N Artificial Bones/Joints
Y N Emphysema
Y N Fainting/Seizures/ Epilepsy
Y N Sever/Freq Headaches
Y N Frequent Neck Pain
Y N Back Problems
Y N Cosmetic Surgery
Y N Xray or Cobalt treat
Y N Chemotherapy
Y N Asthma
Y N Difficulty Breathing
Y N Diabetes/Hypoglycemia
Y N Leukemia
Y N Anemia
Y N High/Low Blood pressure
Y N Bleeding Problems
Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had:____________________

____

Do you snore?____________________

Have you had anyone tell you that you snore?____________________

Do you wake up with headaches or a sore jaw?____________________

Are you allergic to any of the following?

Y N Latex **Y N** Penicillin **Y N** Amoxicillin **Y N** Tetracycline **Y N** Aspirin

Y N Dental Anesthetics:____________________

Y N Foods:____________________ Other Allergies:____________________

Do you use tobacco? No Yes/How used?__________ How much?__________ How long?__________

Please rate your health from 1-10:____________________ **Do you wear contact lenses?** Yes No

For women: Are you taking hormonal birth control such as a pill? Yes No

Are you pregnant? No Yes/How long?__________

Are you nursing? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, or Guardian____________________ **Date**____________________

Update (office use only)

Initials ____________________ Date ____________________ Comments ____________________

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Initials ____________________ Date ____________________ Comments ____________________

LAKE OSWEGO FAMILY DENTISTRY, LLC
FINANCIAL POLICY and PAYMENT AGREEMENT

1. **Policy**. You will be charged whenever you receive care. All payments, including co-pays, are due and payable in full at the time of service. If we both agree that you will pay for a service in installments, you will pay the remaining balance in accordance with this agreement.

2. **Prior Payments**. Payments made before receiving care will be credited against your account. After applying prior payments to your account, you will pay any remaining balance in accordance with this agreement.

3. **Estimated Amount**. You agree to pay to us $________.___ (Estimated Sum). This is an estimate. Other charges may be incurred and, if your insurance changes, the Estimated Sum may change.

4. **Payments Due**. If we both agree that you will pay in installments, as explained above, you will pay the balance in _____ equal monthly installments, payable on or before the _____ day of each month, beginning on the _____ day of the following month in which the charge is incurred. The payments will continue until the balance is paid in full. If we agree to accept more than four payments we will provide you with a Truth In Lending Disclosure Statement.

5. **Additional Charges**. If, prior to paying in full any remaining balance, you incur additional charges, they are due in full at the time of service, as explained above. If we both agree that the additional charges may be paid in installments, you must sign a new Financial Policy and Payment Agreement.

6. **Pre-payments**. You may prepay any or all of the unpaid balance without penalty. However, a partial prepayment does not excuse the obligation to make any payment required under this agreement.

7. **Finance Charges/Late Payments**. Any balance outstanding after 60 days will accrue interest at the rate of 1.5% per month (18% annually). Additionally, the entire balance may be sent to a collection agency and may result in denial of further treatment by us.

8. **Co-payments**. Any co-payments, deductibles, or co-insurance required by an insurance company, as well as payment for non-covered services must be paid at the time of service.

9. **Cancellations**. Any appointment cancelled without 48 hours' notice will result in a late cancellation/no show fee.

10. **Returned Checks**. A fee (currently $25) will be charged for any checks returned by the bank for insufficient funds. ORS 30.701.

11. **Identity Theft Protection**. We will take appropriate measures to verify patient identity and contact information.

12. **Insurance**. Your insurance coverage is a contract between you and your insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill

both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of our charges not covered by insurance. As a courtesy, we allow 60 days for insurance payment to be received. If your insurance company has not made payment to our office within 60 days, you will then be responsible for any existing balance.

13. **Minor Children**. Charges for minor children will be billed to the parent with whom the child resides, or to appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

14. **Attorney Fees**. In the event we must consult an attorney or commence any legal proceeding to interpret or enforce any provision of this agreement, or to collect any amount owing under this agreement, we will be entitled to recover reasonable attorney fees, including the cost of appeal, in addition to the costs and disbursements allowed by law. You will be entitled to recover your reasonable attorney fees from us should you prevail. The amount of the fee will include an amount estimated by the court as the reasonable costs and fees to be incurred by the prevailing party in collecting any monetary judgment or award or otherwise enforcing any order, judgment, or decree entered in a suit or action.

15. **Notice to Patient/Debtor**. DO NOT SIGN THIS AGREEMENT BEFORE YOU READ IT. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT YOU SIGN. KEEP THIS AGREEMENT TO PROTECT YOUR LEGAL RIGHTS.

______________________	______________________________
Date	You
	______________________________
	Patient's Name (if different)

Authorization to Release Dental Records and Radiographs

To Whom It May Concern:

I, ____, hereby authorize and request Dr.________________________________ to send or E-mail copies of all dental radiographs, Perio Charting and summary of dental treatment records for the above patient and family to:

Carrie B. Laird, DMD & Lisa Strauch, DMD, MDSc
454 “A” Avenue
Lake Oswego, OR 97034
503-636-3066
E-Mail: info@lairdstrauch.com

IF YOU HAVE DIGITAL FILMS, PLEASE SEND EACH FILM IN AN INDIVIDUAL J-PEG FILE.

I hereby release the above mentioned doctors from any liability related to disclosure of confidential or privileged information.

Signature: _______________________________

Date: _______________________________