Kooning
FAMILY DENTISTRY

Patient Information

Today's Date: _____/_____/_____

Mr. Mrs. Ms. Dr. Patient is: Policy Holder / Responsible Party / Both

_____

First Name Middle Name Last Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone/Ext Email

_____/____/_____

Birth Date (MM/DD/YY) Social Security No. Drivers License #

Sex: Male / Female

Marital Status: Married Single Divorced Separated Widowed

When best to reach you? Time: _____ Email Text Phone Other

How did you find out about our clinic? Insurance, Internet, Referral_____

Responsible Party: (If other than patient)

_____

First Name Middle Name Last Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone/Ext Cellular phone number

_____/_____/_____

Birth Date (MM/DD/YY) Social Security No. Drivers License State & No.

Dr. Christopher Kooning DMD, PC
15962 Boones Ferry Rd Suite 105 Lake Oswego, OR 97035
Office: 503-675-4594 Fax: 503-675-3503
Kooninglakeoswegodental@gmail.com

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Insurance Information

Primary Insurance:

_____

Name Group No. Member ID

Name of Insured:_____

Patient Relationship to Insured: Self Spouse/Partner Child Other

_____/_____/_____

Insured Social Security No. Insured Birth Date (MM/DD/YY)

_____

Employer of Insured Phone

_____

Address City State Zip

Secondary Insurance:

_____

Name Group No. Member ID

Name of Insured:_____

Patient Relationship to Insured: Self Spouse/Partner Child Other

_____

Insured Social Security No. Insured Birth Date (MM/DD/YY)

_____

Employer of Insured Phone

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Dental Assessment

_____ _____/_____/_____
Patient Name Birth Date (MM/DD/YY)

What are your current dental needs? _____

Do you have another dentist? Yes/ No

Dentist Name: _____ Date of Last Visit: _____/_____/_____

Your current dental health? Good Fair Poor

Are you currently in pain? Yes / No

Do you require antibiotics before dental treatment? Yes / No

Do you floss daily? Yes / No

Brush daily? Yes / No

Do your gums ever bleed? Yes / No

Have you ever had periodontal disease? Yes / No

Are your teeth sensitive to heat, cold, or anything else? Yes / No

Do you have mobility in your teeth? Yes / No

Do you have wisdom teeth? Yes / No

Would you like whiter teeth? Yes / No

Are you happy with the way your smile looks? Yes / No

If not, what would you change?
_____

_____

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Office & Financial Policies

Treatment Policy

Welcome to our office. Dr. Kooning and team are committed to providing you with the best care possible in a comfortable environment. Dr. Kooning will recommend treatment that is individualized to your care and needs. He will offer options that are available to you based on the high standard of care. Our patient coordinator will review your options with you. Dr. Kooning will answer any questions and concerns. Our goal is for you to make an informed decision on what is best for you and your dental health.

Financial Policy

If you have dental insurance, we will gladly answer questions relating to your insurance and help you receive your maximum allowable benefits. Proposed treatment will be reviewed with you with an estimate of insurance percentage of payment and your expected payments per appointment. Payment in full on your portion will be expected when services are rendered. For all laboratory involved services, such as crowns and bridges, we will require full payment prior to beginning of treatment. Balances for services are considered the patient's responsibility. If your insurance company has not paid in full within 40 days of treatment, the balance will be expected from you. Your estimated insurance balance is not a guarantee of payment.

If you do not have dental insurance, full payment is due at time of service.

We accept cash, Visa, MasterCard, American Express, Care Credit, healthcare savings accounts and debit cards. Returned checks will be charged a $40 fee. A monthly statement will be sent to you regarding your account. Please call us at 503-675-4594 if you have any questions concerning your statement.

Appointment Policy

Your appointment time has been reserved specifically to meet your dental needs. Therefore, if you are unable to keep your appointment, we need 48 hours notice to schedule another patient. Failure to notify us within **48 hour,** or to show for your appointment, may result in a **$50.00 fee**. If you arrive more than 10 minutes late for an appointment, we may opt to reschedule the appointment due to lack of adequate time for completion of the procedure. Minor children under the age of 10 must be accompanied by the child's parent or legal guardian for all appointments. The minor may be left alone only if the parent or guardian has given permission and will be accessible by phone and all treatment forms have been signed by parent or legal guardian. Thank you for choosing Dr. Kooning for you dental treatment.

I acknowledge that I am financially responsible for all charges incurred and I assign any insurance payments to be paid directly to Dr. Christopher Kooning DMD. I also authorize the release of any information including diagnosis and treatment records to my insurance company.

Signature: _____ **Date:** _____/_____/_____

Print Name:

_____

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Notice of HIPAA Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment here at Dr. Christopher Kooning DMD, PC Office is to serve our patients with professionalism at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interest it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of Instances where information may be shared:

- during treatment, we may find it necessary to acquire a laboratory's assistance
- during health care operations, we may need a second opinion
- during pending insurance claims, your insurance company may ask to see a copy of an x-ray or other treatment documentation

Dr. Christopher Kooning DMD, PC and Staff are committed to obeying all Federal, State and local laws and regulations regarding Privacy practices. If any other uses or disclosures than the one listed above are needed, information will only be released with the written authorization of the individual in question. The written authorization may be revoked anytime by the individual, as provided for by law.

- I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.
- I authorize Dr. Christopher Kooning DMD, PC to transfer records when necessary on my behalf.

Please list any person we may discuss your dental treatment or billing questions with: _____
Relationship: _____

If you have any questions or comments regarding your protected health information, feel free to call our office at 503-675-4594.

I have read and understand the above notice of privacy practice.

Signature: _____ **Date:** _____/_____/_____

Print Name:
_____

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Medical History

Patient Name: _____ **DOB:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Consent to Treat Minor Without Parent/Legal Guardian

Kooning Family Dentistry

Patient's Full Name: _____

Date of Birth: _____

To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. In the event that a minor child presents for a non-urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

To Consent To:

____ Emergency or urgent care when I cannot be reached.

____ Routine dental care, which may include, but not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays and any and all other treatment previously discussed and agreed upon by the parents/legal guardian.

I can be reached at the following number if there are any questions:

_____.

I/We _____ (printed parent/guardian name) authorize Kooning Family Dentistry to provide treatment.

_____ _____ _____

Signature of Parent/Guardian Relationship to Patient Date

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