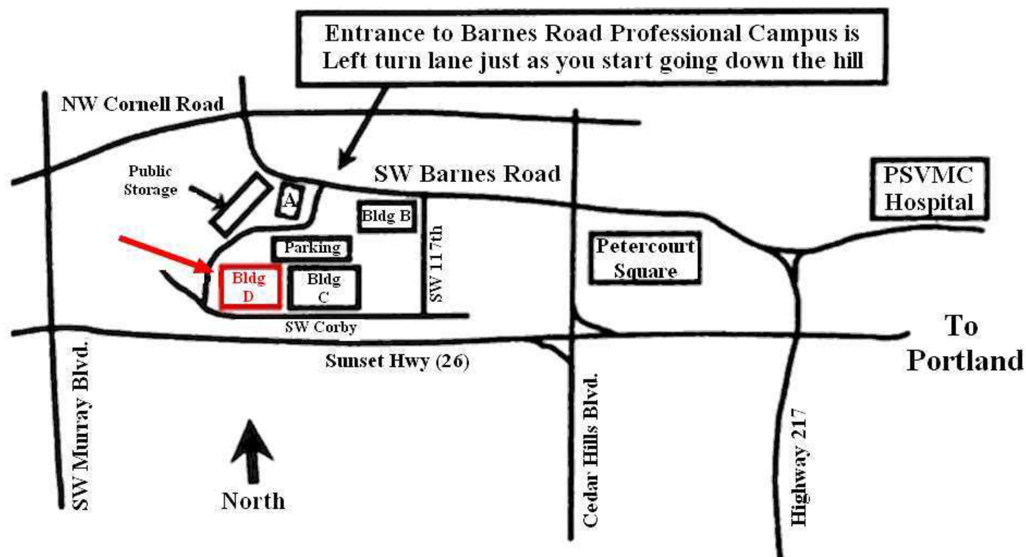
CEDAR CREEK DENTAL

Phil Han, DMD LLC

11786 SW BARNES RD, STE 360
PORTLAND, OR 97225
(503) 646-1811
www.cedarcreekdentistry.com

Directions to the Barnes Road Professional Campus

Our office is located in the Barnes Road Professional Campus in southwest Portland on S.W. Barnes Road two blocks west of S.W. Cedar Hills Blvd. Please call our office for directions if you are unfamiliar with the area.



Coming from Portland on Sunset Highway (26): Take Exit 68 (Cedar Hills Blvd) and turn right onto SW Cedar Hills Blvd. At the first light, turn left onto SW Barnes Rd. Go approximately 0.3 miles and just past SW 117th/Sunset Medical Clinic. Get into the left turn lane and turn into the Barnes Road Professional Campus. Our building (11786) is near the back of the campus behind the parking structure.

Coming from the South on Highway (217): At the North end of Hwy 217, take the Barnes Road exit and then stay in the left lane to head West on Barnes Road. Travel on Barnes Road approximately 0.3 miles past Cedar Hills Blvd and just past SW 117th/Sunset Medical Clinic. Get into the left turn lane and turn into the Barnes Road Professional Campus. Our building (11786) is near the back of the campus behind the parking structure.

Coming from the West on Sunset Highway (26): Take Exit 68 (Cedar Hills Blvd). At the bottom of the ramp turn left on SW Cedar Hills Blvd. At the second light, turn left onto SW
Barnes Road. Go approximately 0.3 miles and just past SW 117th/Sunset Medical Clinic. Get into the left turn lane and turn into the Barnes Road Professional Campus. Our building (11786) is near the back of the campus behind the parking structure.

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REGISTRATION FORM

Thank you for expressing your confidence in choosing our practice! We look forward to assisting you with your dental needs. Please fill out this form in ink only. If you have any questions regarding this form do not hesitate to ask for assistance. We will be happy to help.

Patient Name: ______________________________ Birth Date: ____________

Last M.I. First

SS#:____________________ DL#:______________ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Spouse/Guardian Name:______________________________

Home Address: ______________________________ City/State/Zip: ____________

Home Phone: ______________ Cell: ______________ Work: ____________

Email Address: ______________________________

What is the best way to contact you? ☐ Home ☐ Cell ☐ Email ☐ Work

Employer Name: ______________________________ Occupation: ____________

Spouse/Guardian Name:______________________________

Who may we thank for referring you? ______________________________

RESPONSIBLE PARTY

Name of person responsible for account: ______________________ Relationship:__________

DOB: __________ Age: ________ SS#:______________ Phone: ____________

Address: ______________________________ City/State/Zip: ____________

Employer Name: ______________________________Work Phone: ____________

*Please list an Emergency Contact not living with you. Name: ____________

Phone: ______________________ Relationship: ____________

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Name: ______________________________ Relationship: ____________

DOB: __________ SS#:______________ ID#: ____________

Insurance Company: ______________________________ Group #: ____________

Ins Phone#:______________________ Ins Address: ____________

Employer's Name: ______________________________ Work Phone: ____________

Do you have Secondary Dental Insurance? ☐ YES ☐ NO

Subscriber's Name: ______________________________ Relationship: ____________

DOB: __________ SS#:______________ ID#: ____________

Insurance Company: ______________________________ Group #: ____________

Ins Phone#:______________________ Ins Address: ____________

Employer's Name: ______________________________ Work Phone: ____________

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health care professionals as is beneficial for payment or dental care.

______________________________ ____________

Signature of Patient/Parent or Guardian Date

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Financial Agreement

Thank you for choosing Cedar Creek Dental for your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care easy and manageable for our patients by offering several payment options.

Available Options:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- In office payments extended over 3-months via automatic credit card withdrawal
- Outside financing

Please note:

Cedar Creek Dental requires payment at time of service.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment, however your **ESTIMATED** portion is due at the time of the appointment. Please note we can only **ESTIMATE** what your insurance will remit as your insurance is a contract benefit between you, your employer, and the insurance company. We are happy to assist you in billing your insurance and will do our best to maximize your benefits; however, you are ultimately responsible for the cost of treatment performed.

Please indicate method of payment you prefer:

( ) Payment in full

( ) Automatic credit card withdrawal

( ) Financing plan upon approval

We charge **18%** interest on all past due accounts, **$ 55.00** for appointments missed or cancelled without a minimum of 48 hour notice, and **$35.00** for any returned check.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: ____

Address: ____

____

Telephone: ________________________ Email: _____________________

Social Security #: __________________________ DOB: _______________

Section B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact person: **Letty Brownfield, Office Manager**
Address: 11786 SW Barnes Rd., Ste. 360
Portland, Oregon 97225
Telephone: (503) 646-1811
Fax: (503) 924-1698
E:mail: Office@cedarcreekdentistry.com

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke the consent.

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 use and disclose 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 name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Revocation of consent: I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

Signature: ____ Date: __________________

DENTAL HISTORY

Name ________________________________ Nickname _____________________________ Age ____________

Referred by ___________________________ How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _______________________________ How long have you been a patient? _______________ Months/Years

Date of most recent dental exam ______ /______ /______ Date of most recent x-rays _______ /_______ / ______

Date of most recent treatment (other than a cleaning) ______ / ______ / ______

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ________________
2. Have you had an unfavorable dental experience? ________________
3. Have you ever had complications from past dental treatment? ________________
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ________________
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ________________
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ________________

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ________________
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________________
9. Have you ever noticed an unpleasant taste or odor in your mouth? ________________
10. Is there anyone with a history of periodontal disease in your family? ________________
11. Have you ever experienced gum recession? ________________
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ________________
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ________________

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ________________
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ________________
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________________
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ________________
18. Do you have grooves or notches on your teeth near the gum line? ________________
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________________
20. Do you frequently get food caught between any teeth? ________________

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ________________
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ________________
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ________________
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ________________
25. Are your teeth becoming more crooked, crowded, or overlapped? ________________
26. Are your teeth developing spaces or becoming more loose? ________________
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ___
28. Do you place your tongue between your teeth or close your teeth against your tongue? ________________
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________________
30. Do you clench or grind your teeth together in the daytime or make them sore? ________________
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ____
32. Do you wear or have you ever worn a bite appliance? ________________

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ________________
34. Have you ever whitened (bleached) your teeth? ________________
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ________________
36. Have you been disappointed with the appearance of previous dental work? ________________

Patient's Signature ______________________________________ Date ______________

Doctor's Signature ______________________________________ Date ______________

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MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Name of Physician/and their specialty ______________________________

Most recent physical examination ______________________ Purpose ______________________

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

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury ______
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ________)
   - latex
   - nuts ______
   - fruit ______
   - other ______
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis ______
5. artificial heart valve, repaired heart defect (PFO) ______
6. pacemaker or implantable defibrillator ______
7. orthopedic implant (joint replacement) ______
8. rheumatic or scarlet fever ______
9. high or low blood pressure ______
10. a stroke (taking blood thinners) ______
11. anemia or other blood disorder ______
12. prolonged bleeding due to a slight cut (INR > 3.5) ______
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. tuberculosis, measles, chicken pox ______
15. asthma ______
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ______
18. liver disease ______
19. jaundice ______
20. thyroid, parathyroid disease, or calcium deficiency ______
21. hormone deficiency ______
22. high cholesterol or taking statin drugs ______
23. diabetes (HbA1c = ______) ______
24. stomach or duodenal ulcer ______
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis ______
28. autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ______
30. contact lenses ______
31. head or neck injuries ______
32. epilepsy, convulsions (seizures) ______
33. neurologic disorders (ADD/ADHD, prion disease) ______
34. viral infections and cold sores ______
35. any lumps or swelling in the mouth ______
36. hives, skin rash, hay fever ______
37. STI/STD/HPV ______
38. hepatitis (type ____) ______
39. HIV/AIDS ______
40. tumor, abnormal growth ______
41. radiation therapy ______
42. chemotherapy, immunosuppressive medication ______
43. emotional difficulties ______
44. psychiatric treatment ______
45. antidepressant medication ______
46. alcohol/recreational drug use ______

ARE YOU:

47. presently being treated for any other illness ______
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______
49. taking medication for weight management ______
50. taking dietary supplements ______
51. often exhausted or fatigued ______
52. experiencing frequent headaches ______
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person ______
55. often unhappy or depressed ______
56. taking birth control pills ______
57. currently pregnant ______
58. diagnosed with a prostate disorder ______

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

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 ______

ASA ______ (1-6)

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