Columbia Square Dental

Welcome!

Healthy Smiles for a Healthy Life

Firas Salhi, DDS & Jonathan Kim, DDS

A very warm welcome to you! The entire team would like to thank you for selecting our office to care for your dental needs. Our goals are to provide each patient with the highest quality dental care in a gentle, efficient, and pleasant manner, and to strongly encourage prevention of future dental problems.

- We will put your needs and wishes first and advise you on the best long-term preventive plan for healthy teeth.
- We use only the best material and labs. All instruments go through a steam auto clave for sterilization. All services are rendered with the latest techniques available.
- We base our measure of success on the quality of the relationship we have with each patient, not just on the quality of the dental service we provide.
- We take special interest in helping the fearful or sensitive patient, who may have had difficulty before, and may be avoiding dental treatment because he or she has been hurt elsewhere.

Should you have any questions, please do not hesitate to confide in us regarding any worries you have about your oral health. We'll always take time to answer your questions and give you every reason to smile. That's why we're here.

We have someone on call 24 hours a day, so if you need us – we're here for you. enclosed are the new patient forms, please fill them out and bring them with you to your appointment.

We look forward to meeting and getting to know you.

The Staff of Columbia Square Dental

1320 SW Second Ave. ◆ Portland, OR 97201 ◆ (503) 224-0133

Columbia Square Dental

Welcome!

Healthy Smiles for a Healthy Life

PATIENT INFORMATION **Today's Date:**_____

Name: _____

Birthdate:_____/_____/_____ **Soc. Sec. #:** _____-_____-_____

I identify my gender as: ☐ **Man** ☐ **Woman**

☐ **Genderqueer/Non-Binary** ☐ _____ **(fill in if other)**

Address: _____

City/State: _____ **Zip:** _____

Phone: Hm:(**)** _____-_____ **Cell:(** **)** _____-_____

Employer: _____

RESPONSIBLE PARTY ***(IF, Other than Patient)***

Name: _____

Birthdate:_____/_____/_____ **Soc. Sec. #:** _____-_____-_____

Address: _____

City/State: _____

Zip: _____ **Phone: Hm: (** **)** _____-_____

Wk :(**)**_____-_____ **Cell: (** **)** _____-_____

Employer: _____

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

Please circle your method of payment today;

CASH • CHECK • CREDIT CARD • CARE CREDIT

Preferred Method of Receiving Appointment Confirmations

❒ **PHONE** ❒ **TEXT** ❒ **EMAIL**: _____

Preferred Pharmacy:

PRIMARY INSURANCE INFORMATION

SUBSCRIBER: ☐ **Self** ☐ **Other** ***(Fill out below)***

Name: _____

Birthdate: _____ **Relation to Patient:**_____

Ins. Company: _____

Group #: _____ **Phone #:** _____

Address: _____

City/State: _____ **Zip:** _____

Employer: _____

Soc. Sec. # / ID#: _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER: ☐ **Self** ☐ **Other** ***(Fill out below)***

Name: _____

Birthdate: _____ **Relation to Patient:**_____

Ins. Company: _____

Group #: _____ **Phone #:** _____

Address: _____

City/State: _____ **Zip:** _____

Employer: _____

Soc. Sec. # / ID#: _____

Spouse's Name: _____ **Employer:** _____ **Wk #: (** **)** _____-_____

Emergency Contact:_____ **Phone #: (** **)** _____-_____

Is another member of your family or relative a patient at our office:

Name: _____ **Relationship:** _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PATIENT CONSENT FOR TREATMENT

1) I authorize the doctor / staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs.
2) Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3) I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

MEDICARE

I understand that Columbia Square Dental has ***opted out of Medicare***. This should have little or no effect on me since Medicare does not cover most dental services. By opting out, neither I nor Columbia Square Dental can bill Medicare for any dental services rendered.

INSURANCE

Insurance will be billed according to the billing / payment guideline of my primary insurance. **I understand that as a courtesy, Columbia Square Dental will submit insurance claims on my behalf; however, they do not guarantee any payment of benefits.**

If my insurance coverage does not cover the estimated amount, I will be responsible for payment in full. Additionally, if I fail to provide accurate insurance information to the business office within 15 days of the date of service, I will be expected to pay the account in full and get reimbursed from my insurance carrier.

Deductibles, co-insurance, non-covered services (including pre-existing conditions), and services denied due to insurance eligibility is my responsibility. I authorize my insurance company(s) to pay Columbia Square Dental all Insurance benefits for dental services rendered to me or members of my family.

FINANCIAL AGREEMENT

I agree to be responsible for payment of all services rendered on my behalf or my dependents. **I understand that payment is due at the time of service unless other arrangements have been made.** In the event that payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18% APR) may be added to my account.

Additional Charges:

- I know that ***I must call to cancel an appointment at least 24 hours*** (1 day) before the time of the appointment. If I do not cancel and do not show up a $50 charge will be assessed for time reserved and future appointments will need to be prepaid.
- I understand that **delinquent accounts** will be assigned to a credit reporting collection agency and I will be charged a *$100* collection fee.
- I understand that a $25 fee will be charged to transfer records electronically.

HIPAA

Release of Information:

- I give consent to the doctor's or designated staff's use at Columbia Square Dental to disclose any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, referral to other healthcare professionals and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

- I would like a copy of this office's "Notice of Privacy Practices"? ❒ **Yes** ❒ **No**

(If box is left un-checked, we will assume you do not want a copy)

I acknowledge that I read English and have read and understood the contents of this form. I agree to adhere to the Above policies of Columbia Square Dental

Print Patient Name	**Signature of Patient, Parent or Guardian**	**Date**

Medical History:

THE PATIENT'S RESPONSIBILITY is to provide accurate/complete information about current and past illnesses, medications including herbal supplements, and other matters pertaining to their health and medical history. Success of treatment depends on your disclosure. If treatment fails due to lack of disclosure of a medical condition or medication that you are taking; you may incur additional expenses for alternative additional treatment.

If answering yes, to any of the following questions, please explain in space provided		
Are you undergoing Medical treatment at this time?	☐ **Yes** ☐ **No**	
Have you ever been hospitalized or had a major operation?	☐ **Yes** ☐ **No**	
Have you ever had a serious head or neck injury?	☐ **Yes** ☐ **No**	
Are you taking any medications, pills, or drugs? Do	☐ **Yes** ☐ **No**	
you take or have you taken, Phen-Fen or Redux?	☐ **Yes** ☐ **No**	
Are you on a special diet?	☐ **Yes** ☐ **No**	
Do you smoke or use tobacco?	☐ **Yes** ☐ **No**	
Do you use controlled substances? Are	☐ **Yes** ☐ **No**	
you being treated for Osteoporosis?	☐ **Yes** ☐ **No**	
Are you taking **Fosamax, Boniva or Actonel?**	☐ **Yes** ☐ **No**	

WOMEN: Are you Pregnant / trying to get pregnant? ☐ **Yes/**☐ **No** Taking Oral Contraceptives? ☐ **Yes/**☐ **No** Nursing? ☐ **Yes/**☐ **No**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Local Anesthetics ☐ Other - If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

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

Have you ever had any serious illness not listed above? ☐ **Yes** ☐ **No** If yes, please explain: _____

Do you snore or stop breathing during Sleep? ☐ **Yes** ☐ **No** If yes, please explain: _____

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 medical changes.

Print Patient Name **Signature of Patient, Parent or Guardian** **Date**