Columbia Square Dental

Welcome!

Healthy Smiles for a Healthy Life

Firas Salhi, DDS | Terrylynn Tennant, DMD, AADSM

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 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 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: _____

Comments: _____

Medical History Continued:

FAMILY HISTORY: Do you have a family history of any of the following medical illnesses? (Check "yes" to all that apply)

High blood pressure/ Hypertension	☐ Yes ☐ No	Restless legs Syndrome	☐ Yes ☐ No	Chronic Insomnia	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Overweight./ Obesity	☐ Yes ☐ No	Diabetes Type:	☐ Yes ☐ No I or II	Congestive Heart Failure	☐ Yes ☐ No	Sleep Walking	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No	Snoring	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No				

DENTAL HEALTH HISTORY: (Check "yes" to all that apply)

Are you apprehensive about dental treatment?	☐ Yes ☐ No	Does food catch between your teeth?	☐ Yes ☐ No **Please specify:**	Does your jaw make noise that bothers you/others?	☐ Yes ☐ No	Do you find jaw pain frustrating or depressing?	☐ Yes ☐ No
Have you had problems with previous dental treatment?	☐ Yes ☐ No	Do your gums bleed easily?	☐ Yes ☐ No	Does your jaw ever feel tired?	☐ Yes ☐ No	Does jaw pain affect your sleep, daily routine/activities?	☐ Yes ☐ No
Do you snore?	☐ Yes ☐ No	Do your gums bleed when you floss?	☐ Yes ☐ No	Does your jaw hurt when you chew or open wide to take a bite?	☐ Yes ☐ No	Do you have pain in the face, cheeks, jaws, joints, throat or	☐ Yes ☐ No
Have you ever noticed slow-healing sores in or around your	☐ Yes ☐ No	Do your gums feel swollen or tender?	☐ Yes ☐ No	Do you have jaw symptoms or headaches upon awakening?	☐ Yes ☐ No	Do you have a temporomandibular (jaw) disorder (TMD)?	☐ Yes ☐ No
Do you chew on only one side of your mouth?	☐ Yes ☐ No	Do you feel pain with any of the following: Hot, cold, sour or sweet foods/liquids?	☐ Yes ☐ No	Have you ever had a serious injury/trauma to your mouth, head or jaw	☐ Yes ☐ No	Are you unable to open your mouth as far as you want?	☐ Yes ☐ No
Do you take fluoride supplements?	☐ Yes ☐ No	Do you have difficulty chewing your food?	☐ Yes ☐ No	Do you have ear-aches or pain in the front of your ears?	☐ Yes ☐ No		
Do you gag easily?	☐ Yes ☐ No	Does your jaw clench or grind frequently?	☐ Yes ☐ No	Are you aware of an uncomfortable bite?	☐ Yes ☐ No		

Have you ever had: (check all that apply)

☐ Orthodontic Treatment? ☐ Oral Surgery ☐ Periodontal treatment? ☐ Bite adjustment?

How often do you brush? _____ **Floss?** _____

Are you happy with your smile? ☐ **Yes** ☐ **No** **If not, what would you change?** _____

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.

_____ _____ _____

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

Columbia Square Dental

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

This refers to your usual way of life in recent times. Even if you have not done some of these things in the past few days, try to work out how you usually are affected.

Use the following scale to choose the most appropriate number for each situation.

0 = No chance of dozing

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (like a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

ANALYZE YOUR SCORE:

From 0-7	It is unlikely that you are abnormally sleepy
From 8-9	You have an average amount of daytime sleepiness
From 10-15	You may be excessively sleepy, depending on the situation. You may want to consider seeking medical attention.
From 16-20	**You are excessively sleepy and should consider seeking medical attention**