JEREMY ARCHIBALD DDS

FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION

Welcome! To assist us in serving you, please complete the following forms. The information provided is strictly confidential, and will be used to provide personalized and individual care. If you have any questions, please do not hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____

Home address: _____

City:_____ State: _____ Zip: _____

Billing address (if different): _____

City: _____ State: _____ Zip: _____

Email address: _____

Home telephone: _____ Cell Phone: _____ Bus. Phone:_____

Preferred Method of Contact:

☐Home Phone ☐Cell Phone ☐Business Phone ☐Email

Emergency Contact Name (relationship): _____Emergency Contact #_____

SS#: _____ Drivers License #:_____

Employer/Occupation: _____

Primary Dental Insurance

Primary dental insurance: _____ Group #: _____ Phone #: _____

Insurance Company Address: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Subscriber's employer: _____

Secondary Dental Insurance

Secondary dental insurance: _____ Group #: _____ Phone #: _____

Insurance Company Address: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Subscriber's employer: _____

I certify that I have read and answered all questions on intake forms truthfully and to the best of my knowledge. I authorize Dr. Archibald & employees to release any information including the diagnosis and records of any treatment or examination rendered to me or my dependents to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to Dr. Archibald. I authorize Dr. Archibald to perform an initial examination and obtain necessary radiographs (x-rays) to evaluate my oral condition and provide a diagnosis to me.

Signature of Patient (or parent/guardian if minor):_____ Date:_____

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Patient Health History

Patient's Name _____ **Today's Date** _____

Date of Birth _____

Please rate your health. □ **Excellent** □ **Very Good** □ **Good** □ **Fair** □ **Poor**

Has there been a change in your general health in the past year? □ **Yes** □ **No**
If so please explain:_____

Are you currently under treatment by a physician? □ **Yes** □ **No**
Name primary care physician _____ **Date of last MD visit** _____

Have you been hospitalized for a serious illness or injury during the last five years?
If so please explain: _____

_____

Have you experienced an allergic or unusual reaction to any of the following? □ **NO**

□ **Penicillins** □ **Opiates/Codeine** □ **Other drugs or substances:**
□ **Sulfa drugs** □ **Latex** **List: 1.** _____
□ **Aspirin** □ **Local Anesthetics** **2.** _____
3. _____

Please list all prescription/non-prescription medications (including vitamins and herbal medications) that you regularly take (Please provide list if space is inadequate)

_____

_____

Do you use tobacco? □ **Yes** □ **No** **Do you vape?** □ **Yes** □ **No**
How often/what form _____ **Do you smoke marijuana** □ **Yes** □ **No**

Have you ever taken Fosamax, Boniva, Actonel, Zometa, Reclast or any other medication containing bisphosphonates? □ **Yes** □ **No**

***Women, are you** □ **Pregnant** □ **Trying to get Pregnant** □ **Nursing**

Mark any conditions or symptoms that you NOW experience or HAVE previously experienced.

□ **High Blood Pressure**
□ **Heart Attack**
□ **Angina (chest pain)**
□ **Stroke**
□ **Pacemaker**
□ **Heart Valve Disease**
□ **Irregular Heartbeat**
□ **Congestive Heart Failure**
□ **High Cholesterol**
□ **Diabetes (**Type_____**)**
□ **Autoimmune disorder**
□ **Thyroid Disease**
□ **Arthritis/Gout**
□ **Skin Disorders**
□ **Kidney Disease**
□ **Liver Disease**
□ **Ulcers/Irritable Bowel**
□ **Reflux/Frequent Heartburn**
□ **Epilepsy or Seizure Disorder**
□ **Alzheimer's Disease/Dementia**
□ **Autism Spectrum Disorder**
□ **Mental Illness**
□ **Neurologic Disorders**
□ **Anxiety/Depression**

□ **Asthma/Shortness of Breath**
□ **Emphysema/Bronchitis**
□ **COPD**
□ **Anemia**
□ **Bleed or Bruise Easily**
□ **Tuberculosis**
□ **Sexually Transmitted Disease**
□ **Herpes Infection (Cold Sores)**
□ **Hepatitis:** Type_____
□ **Tuberculosis**
□ **HIV**
□ **Cancer:** Type_____
□ **Radiation/chemotherapy**
□ **Organ Transplant:**_____
□ **Frequent Headaches**
□ **Drug/Alcohol Abuse**
□ **Hay Fever/Seasonal Allergies**
□ **Chronic Pain**
□ **Prosthetic Joint/Implant**
Explain_____

Do you have any diseases or conditions not mentioned above? _____

_____

_____

Dental History

Do your gums bleed while brushing or flossing? □ **Yes** □ **No**
How many times each day do you brush? _____ **Type of brush**_____
How many times a week do you floss?_____
Do you have any teeth that are difficult to floss? □ **Yes** □ **No**
List any mouthrinses or other oral hygiene aids you use? _____
Are your teeth sensitive to hot/cold liquids or food? □ **Yes** □ **No**
Are your teeth sensitive to sour or sweet foods? □ **Yes** □ **No**
Do you have any sores or lumps in/around your mouth? □ **Yes** □ **No**
Do you experience a chronic dry mouth? □ **Yes** □ **No**
Have you experienced any of the following?
Clicking, popping, noise in your jaw joints □ **Yes** □ **No**
Pain in joint, ear, or side of face □ **Yes** □ **No**
Difficulty opening or closing your mouth □ **Yes** □ **No**
Do you have a difficult time chewing your food? □ **Yes** □ **No**
Have you had orthodontic treatment (braces)? □ **Yes** □ **No**
Have you ever received treatment for periodontal disease (deep cleanings, gum surgeries, etc.)? □ **Yes** □ **No**
Do you wear a complete or partial denture? □ **Yes** □ **No**
Have you ever had dental implants? □ **Yes** □ **No**
Have you ever had difficulty with any previous dental treatment? Please Explain_____ □ **Yes** □ **No**
Are you apprehensive about receiving dental care? □ **Yes** □ **No**
What has worked well in the past to manage your anxiety?_____
What would like to change about your smile or your dental health?

_____

_____

Patient's Signature_____ **Date**_____

Reviewed by _____ **Date**_____

JEREMY ARCHIBALD DDS

FAMILY & COSMETIC DENTISTRY

Financial Agreement

An investment in your smile and oral health pays dividends for a lifetime. We are eager to help you achieve your dental goals and assist you in having the best oral health and smile you deserve.

Payment is due in full at the time of service. This applies to insurance deductibles and any portion estimated to not be covered by insurance. Your prompt payment is appreciated. For your convenience, we accept cash, check and Visa/Mastercard/Discover. For those who wish to extend payments over a period of time, financing is available through a third party provider, Care Credit™.

Patients without Dental Insurance

Charges are required to be paid for in full at time of service. An estimate of your expected charges will be provided for you at your examination/consultation appointment or prior to your dental treatment appointment. A 5% discount is offered to our cash patients when they pay in full on the day of service. Due to processing fees, we cannot provide this discount to those paying with credit/debit cards or **Care Credit™** accounts.

Dental Insurance

As a courtesy to our insured patients, we accept payments from most insurance companies. Insurance estimates are based on information obtained from your insurance company. The amount of coverage your insurance company will pay for a given service is determined by the level of coverage provided in your insurance agreement. We will provide an estimate to you on how much we expect your insurance will pay for treatment costs, based on contact with your insurance company and past history of payments from your insurance. While we are happy to help you with claims submission**, *we can make no guarantee about insurance payments*.** If your insurance company declines financial coverage/denies coverage for a service we have provided you, **for any reason**, it will be your obligation to pay for performed services, regardless of the estimate provided.

Family Members and Children

Unless other arrangements have been made, the legal guarantor is responsible for payment of services provided. For children wishing to come without a parent following the initial appointment, financial agreements must be made prior to their dental appointment.

Missed appointment

We value your time and consequently try to provide you with appointment times that are convenient with your schedule. We anticipate that you will arrive for **your reserved time** with the doctor and hygienist so that we can provide the dental care you need. We appreciate that sometimes conflicts come up that are out of your control and are willing to find another appointment time that better fits your schedule. Please give us **48 hours notice (two working days)** prior to your reserved appointment time so that we may schedule another patient (often emergencies) in your allotted time**. A missed appointment is a loss to everyone**. We retain the right to charge a "missed appointment fee" of $50 for patients that do not arrive for their reserved appointment without appropriate notice.

I hereby authorize payment directly to Jeremy Archibald DDS, PC of the insurance benefits otherwise payable to me. I also authorize release of any information, including the diagnosis, records collected to make a diagnosis and treatment rendered to my insurance company. Returned checks will incur a fee of $35. **Payment is due upon receipt of invoice for any previously unpaid balances**. Online bill pay is available on our website, www.doctorarchibald.com . If it becomes necessary to utilize collection services for unpaid balances over 90 days, the guarantor on the account agrees to pay for all costs and expenses, including reasonable attorney fees, required to collect the balance owed.

Printed name: (patient)_____ Date:_____

Signature: (patient)_____

Printed name: (guarantor if different)_____ Date:_____

Signature: (guarantor if different)_____

JEREMY ARCHIBALD DDS

FAMILY & COSMETIC DENTISTRY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: _____ Date of Birth: _____

I hereby authorize dental providers and personnel of Jeremy Archibald DDS. Family and Cosmetic Dentistry, to discuss my protected health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization shall be in force and effective from _____(date), and indefinitely, until I shall change or terminate authorization to share protected health information with the aforementioned individuals.

I understand that/ have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that Jeremy Archibald DDS, Family & Cosmetic Dentistry has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Jeremy Archibald DDS, Family & Cosmetic Dentistry will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under applicable state and federal low. I understand that I also have the right to refuse to sign this authorization. This authorization will remain in force unless authorization is revoked or changed in writing. To the extent permitted by the low, the office, its employees, officers, and doctors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient/Authorized legal Representative: _____ Date: _____

Printed name of Patient/Authorized Legal Representative: _____

Description of Authorized Legal Representative: _____

Jeremy Archibald, DDS Family & Cosmetic Dentistry

Notice of Privacy Practices

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 organization is committed to providing you with medical care that meets your needs. An important aspect of our service commitment to you is the protection and security of the protected health Information that we obtain about you. We have always safeguarded your health information and our written privacy policy gives us an opportunity to share with you our policies that protect your health information.

We are required by law to provide you with this notice. It will describe to you what protected health information we collect about you and how that information might be used.

The Type of Protected Health Information That We May Obtain About You:

Demographic information: including your name, address, date of birth, phone number{s), name of your employer, your spouse or other family members, and emergency contact.

Insurance Information: including your insurance carrier, the name of the insured person, insurance identification numbers, and benefits and eligibility information.

Health Information: including your health history, past illnesses or injuries, family medical history, your social activities including use of tobacco, alcohol, or drugs, family life and living situation, your current and or ongoing health problems, including medications, allergies, advised treatment and outcomes of that treatment

Payment Information: including your insurance carrier, your record of charges, adjustments, and payments to our organization.

How We Mav Use and Disclose Protected Health Information About You:

Section1:
We are not obligated to have your consent when using or disclosing protected health Information for the following purposes:

A. **For Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and any related services. We may disclose information about you to doctors, dentists, nurses, technicians, office staff or other personnel Who are involved in taking care of you and your health.

For example:

- *If we schedule a test therapy or surgery for you, we must provid9 information about you in order to complete the scheduling. This includes your name, demographic and Insurance information and the reason for the test.*
- *Your doctor may share your medical information with another doctor who is also involved in your care so that both may have all the information to make the best treatment decisions for you.*
- *We may share information with a pharmacy so that they can fill or refill a prescription for you.*
- *We may share information about you with another provider who is on call in the absence of your provider.*

B. **For Payment**: We may use and disclose your information to obtain payment for services you receive. If you pay in full for service out of pocket you have the right to restrict your information being given to any health plan.

For example:

- *We may use or disclose your information to determine eligibility for insurance or benefits.*
- *We may use the name of your insurance canier and your identification numbers in order to file a claim for you.*
- *We may disclose your information about your conditions or reasons for seeking care and the care that is provided to your insurance carrier so that they may process and pay your claim.*
- *We may disclose information about your conditions to your insurance carrier to seek approval as necessary for recommended tests and treatment.*

- *We may provide information about your services to* a *health care clearinghouse* so *that they may distribute* a *claim to your insurance carrier* on *our behalf.*
- *If we refer you to another facility or provider we may provide them with your insurance information to expedite your registration and* assure *that they are participants in your insurance plan.*

C. **For Health Care Operations**: We may use or disclose protected health information about you in order to evaluate our care for you or to meet a business need of the organization. These activities include quality assessment activities, employee review activities, training students, compliance audits by your insurance carrier, and conducting or arranging for other business activities.

For example:

- *We may use information about you to evaluate the performance of our staff in caring* for *you.*
- *We may use your information* to *evaluate our efficiency.*
- *We may* use *your information to evaluate and respond to* a *patient complaint.*
- *We may share your health information with students or residents who am teaming* to *care for patients.*

We may also use or disclose protected health information to our Business Associates in the performance of health care operations. A Business Associate is an entity or person engaged by this organization to perform a business activity on behalf of the organization. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

For example:

- *We may provide information to our transcription service* so *that they can produce* a *written copy of your encounter in our office.*
- *We may provide information* to *our accountant in order to prepare our organization's financial reports.*
- *We may* share *information with qualified consultants in order* for *them to provide business management advice.*

D. **Other Contact Situations**:

- *We may use your information to call and remind you of an appointment in our office.*
- *We may tell you about or recommend possible treatment options or alternatives that maybe of interest to you.*
- *We may tell you about health-related products or services that may be of interest to you.*
- *We may use your information for marketing and fundraising. You do have the right to optout of the marketing and fund raising information.*

E. **Special Situations:**

Emergencies: We may use or disclose protected health information in the case of a medical emergency.

Required by Law: We may use or disclose your protected health information if the disclosure is required by law.

Public Health: We may disclose protected health information about you for public health activities. These activities generally include the following:

- *To prevent or control disease, injury or disability*
- *To report births or deaths*
- *To report child abuse or neglect*
- *To report reactions to medications or problems with products*
- *To notify a person who may have been exposed to a disease or maybe at risk for contracting or spreading a disease or condition*
- *To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.*

Health Oversight: We may disclose protected health information to health oversight agencies that oversee our activities. These activities may include audits, investigations and inspections and are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to legal requirements, we may also disclose medical information about you in response to a subpoena.

Law Enforcement: We may disclose protected health information, so long as all applicable legal requirements are met, for law enforcement purposes.

Coroners, Medical Directors and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Information about patients to funeral directors as necessary to carry out their duties.

Workers Compensation: We may disclose medical information about you for programs that provide benefits for work-related injuries or illness.

Military Activities, National Security and Intelligence Activities: If you are a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to disclose protected health Information about you. We may also disclose information about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donation: If you are an organ or tissue donor, we may disclose protected health information to organizations that handle organ or tissue procurement when necessary to facilitate organ or tissue donation or transplantation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. The release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Information that is not personally identifiable: We may use or disclose information about you in a way that does not personally identify you.

Section 2:
Protected Health Information Use and Disclosure That Requires an Opportunity for You to Agree or Object

Family and Friends: We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

If you are not available, we will determine whether a disclosure to your family or friends Is In your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Section 3:
Protected Health Information That Cannot Be Disclosed Without Your Specific Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may revoke this authorization by notifying us in writing at any time.

Your Rights as a Patient:

- **You have the right to Inspect and copy your protected health information.**

You may inspect and obtain a copy of your protected health information maintained in our office. We may charge you for the cost of copying, mailing or associated supplies.

Under federal law, however, you may not inspect or copy psychotherapy notes or Information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. Certain documents pertaining to laboratory services are also exempt under federal law.

You have the right to an electronic copy of your records.

You have the right to request your records be sent via e-mail with the understanding that we will try and verify your email before sending. E-mail is not always secure and you are acknowledging this fact. This request must be done in writing.

Under certain circumstances, we may not grant your request. If we deny your request, then you may appeal our decision.

We require that requests to access your protected health information be made in writing. You can arrange to do this through our Privacy/Security Officer.

- **You have the right to request a restriction of your protected health information.**

You may ask us not to disclose your protected health information for treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends and/or family members involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information Is needed to provide you with emergency care.

In order to request a restriction, you must do so in writing. The request must specifically state what information is restricted and to whom the restriction applies.

You may request a restriction form from our Privacy/Security Officer.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

You may request that we communicate with you in a certain way or at a specific location. We will attempt to accommodate all reasonable requests.

Please contact our Privacy/Security Officer to make this request in writing. Your request must specify where or how the communication is to be directed.

- **You have the right to request that we amend your protected health information.**

If you believe that protected health information we have about you is incorrect or incomplete, you may request an amendment to this information.

We may not grant your request if we determine that the protected health information that is the subject of your request:

- *was not created by our organization*
- *is not a part of your medical or billing records*
- *is information that you are not permitted to inspect or copy*
- *is already a complete and accurate record*

Amendment requests must be made in writing and must Include a reason for requesting the amendment. If you wish to amend your record, you may contact our Privacy/Security Officer for a form.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your your protected health Information.**

You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than you, except for disclosures:

- *to carry out treatment, payment and health care operations as described above*
- *to persons involved in your care or for other notification purposes as provided by law*
- *for national security or intelligence purposes as provided by law*
- *to correctional institutions or law enforcement officials as provided by law*
- *that occurred prior to April 14, 2003*

You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, we may charge you the cost of providing the disclosure list.

Your request for a disclosure accounting must be made in writing. Please contact our Privacy/Security Officer to obtain a form.

- **You have the right to file a complaint.**

If you believe that your privacy rights have been violated, you have a right to file a complaint In the form of a written letter with our office and with the Secretary of Health and Human Services without fear of retaliation.

A letter of complaint filed with this office should be sent to our Privacy/Security Officer at the address listed below.

- **You have the right to request and receive a paper copy of this notice from our office.**

Revisions to Our Privacy Notice:

We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any lime. The new notice will be effective for all protected health information that we maintain at that time. This notice is in effect as of September 23, 2015 Upon your request, we will provide you with a revised Privacy Notice. You may obtain this by calling our office and requesting that a revised copy be sent to you in the mall, or by asking for one at the time of your next appointment.

Questions/Contact:

If you have questions about this document. or have questions about privacy or patient rights, please contact our Privacy/Security Officer.

Privacy Officer Name: Sara B.

Address: 742 NE Division,.Ste. 101
Gresham, OR 97030

Phone Number: 503-665-7017

Jeremy Archibald, DDS Family & Cosmetic Dentistry

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Notice of Privacy Practices.

The Notice of Privacy Practices explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Notice of Privacy Practices, please feel free to direct these to our Privacy/Security Officer at any time. The name and contact number of the Privacy/Security Officer is listed on your copy of the Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

Patient to complete this section

I have received a copy of the Notice of Privacy Practices for this organization on today's date.

Signed: _____ Date:_____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Notice of Privacy Practices was provided to:

Patient Name: _____ On _____

The patient was unable to acknowledge receipt of the Notice of Privacy Practices for the following reason:

_____

_____

_____

Signed _____

File this form in the *patient's chart*