Trails End Dental
Douglas Retzlaff, DMD
Prevent • Restore • Maintain

WELCOME

The benefits of a happy, healthy smile are immeasurable! It is our goal to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____ E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female ☐ Other

Birthdate: ____/____/____ Age: _____ SS#: _____

Home Address: _____
Apt/Condo#

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____) _____ Pager / Cell #: _____

Wk #: (_____) _____ Ext: _____

Employer: _____

Employer's Address: _____

Where & when are best time to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
Please Circle

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (_____) _____ Ext: _____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Person Responsible for Account: _____

Wk #: (_____) _____ Ext: _____ Hm #: (_____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: (_____) _____

Address: _____

_____
City State Zip

CONTINUED ON BACK

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs / materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. 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 release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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1104 Molalla Avenue
Oregon City OR 97045
Phone (503) 656-7131 | Fax (503) 656-6382
trailsenddental.com | info@trailsenddental.com

Appointment Policy

It is our goal to support our patients in keeping their appointments. We make confirmation calls the day before a scheduled appointment and postcard reminders are mailed two weeks in advance for your pre-scheduled Continuing Care appointment.

If you are unable to keep an appointment, kindly give 24 hours notice.

Failure to keep an appointment and/or give notice becomes a 'no cancel/no show' appointment. We reserve the right to charge $50 for this time reserved. A second 'no cancel/no show' appointment indicates to us the patient-office relationship is not working and results in the issuing of a 30-day written notice of dismissal from the practice. Only emergency care will be provided within that time period.

Signature_____Date_____

Your signature indicates that you understand the reason for the charge and payment is your responsibility.

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Insurance

As a courtesy our office will assist with electronic claims filing to your insurance company, however, it is your responsibility to know your insurance benefits, coverage, and limitations.

Financial Policy

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment options:

- Payment in full at time of service. For your convenience we accept cash, checks, Visa, MasterCard, and Discover.
- Auto-debit to your credit or debit card on file.
- CareCredit payment plans.

I agree to pay a finance charge of 18.9% APR on any balance on my account over 60 days.

_____ _____

Signature of Responsible Party Date

Trails End Dental

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

Trails End Dental

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 May Use and Disclose Protected Health Information About You:

Section 1:
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 provide 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 carrier 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 are learning 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 may be 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 fund raising you do have the right to opt out 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 may be 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 health care 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 however this office does not have electronic records. However we will copy your paper chart if requested in writing.

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 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 time. 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 mail, 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: Kelsey Cook

Address: 1104 Molalla Avenue
Oregon City, OR 97045

Phone Number: 503-656-7131