4 Seasons Dental / Dr. Todd Schroeder
New Patient Registration

Patient Info

First Name: _____ Last Name: _____

Address: _____

City / State / Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status: _____

E-mail Address: _____

Birth Date: _____ Social Security #: _____

How did you hear about us? ☐ Mailer ☐ Internet Search/Website ☐ Facebook ☐ Instagram ☐ Twitter

☐ Referred by: _____ ☐ Other _____

Responsible Party Info

☐ Same as above (self) ☐ Spouse ☐ Parent ☐ Other _____

First Name: _____ Last Name: _____

Address: _____

City / State / Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status: _____

E-mail Address: _____

Birth Date: _____ Social Security #: _____

Appointment Reminders

How would you like to be reminded of your appointments? ☐ Text reminder ☐ E-mail reminder ☐ Phone call

Insurance Info

☐ **I DO NOT have dental insurance coverage at this time**

☐ **I have the insurance coverage listed below - Please present your insurance card(s) at time of check in.**

PRIMARY INSURANCE COMPANY: _____ Member ID: _____

☐ I have insurance through my employer - Name of employer: _____

☐ I am insured on someone else's policy - Name of primary insured: _____

☐ I am self-insured

SECONDARY INSURANCE COMPANY: _____ Member ID: _____

☐ I have insurance through my employer - Name of employer: _____

☐ I am insured on someone else's policy - Name of primary insured: _____

☐ I am self-insured

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X

Date:_____

Airway Health Questionnaire

Patient Name: _____ Date:_____

Have you been prescribed a CPAP? ❒ Yes ❒ No **If so, do you use it? ❒ Yes ❒ No**

Please answer the following questions if you do NOT use a CPAP

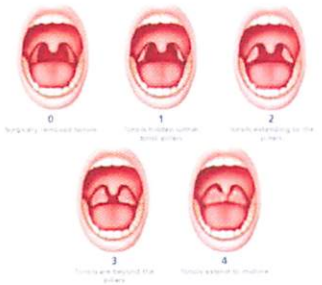
Y	N	8	Have you ever been told you stop breathing while asleep?
Y	N	6	Have you ever fallen asleep/nodded off while driving or during a conversation?
Y	N	6	Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
Y	N	4	Do you feel excessively sleepy during the day?
Y	N	4	Do you snore or have you ever been told that you snore?
Y	N	2	Have you had weight gain and found it difficult to lose?
Y	N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y	N	3	Do you kick or jerk your legs while sleeping?
Y	N	3	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y	N	3	Do you wake up with headaches during the night or in the morning?
Y	N	4	Do you have trouble falling asleep?
Y	N	4	Do you have trouble staying asleep once you fall asleep?

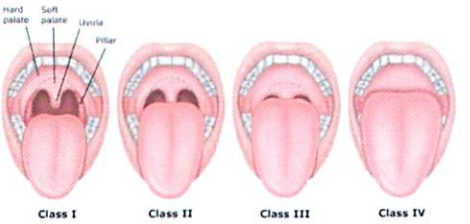
—— SCORE

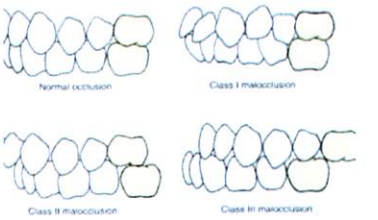
Score and Risk Factor (Add the points that you have answered "YES")

Low 0-7	Moderate 8-11	High 12-15	Sever 16+

FOR OFFICE USE ONLY







❒ Clenching/grinding
❒ High arched palate
❒ Nasal septum deviation
❒ Nasal congestion
❒ Anterior gingivitis
❒ Overbite greater than 80%
❒ Periodontal disease
❒ Pre-molar extraction
❒ Battered uvula

❒ Abfraction
❒ Acid erosion/wear
❒ Forward wear pattern
❒ Scalloped tongue
❒ Lingual tori
❒ Large tongue
❒ Palatal tori/exostoses
❒ Tongue tie _____%
❒ Forward head posture

❒ Bags under the eyes
❒ Lingualized dentition
❒ Allergies/medication
❒ Pharyngeal walls
❒ Gag reflex
❒ Mouth breathing
❒ Overclosure
❒ Headaches/when/where

The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

4 SEASONS DENTAL
Todd Schroeder DDS

Office Policy

Thank you for choosing 4 Season Dental as your dental provider! We look forward to working with you and providing you with high quality care.

When scheduling your appointments, we are making a commitment to you, as well as you to us. Our schedule is usually very full, so if you must miss an appointment, please notify us 48 hours before your appointment, so we can make that time available to other patients who are waiting for an appointment. Late cancellations or missed appointments are grounds for dismissal.

Payment is due the day of your treatment. This includes the patient portion for those who have insurance. Please bring your payment with you.

We will bill your insurance as a courtesy to you. If any amounts are denied or not covered, the balance owing is your responsibility. The estimated patient portion we give you on the day of your treatment on **ONLY AN ESTIMATE** and may change depending on the final amount the insurance company pays. Patient is responsible for entire amount if insurance denies payment.

Checks returned for insufficient funds are subject to a $35.00 fee.

We do not bill state assisted insurance, including but not limited to OHP, EOCCA, Washington Apple Health, and Medicaid/Medicare. By signing below, you declare that you are not a recipient of state assisted insurance, OR if you are a recipient, you are stating that you are fully aware that our office will not bill any state insurance nor are we a provider for state insurance, and you are responsible for the entire treatment charge.

By signing you acknowledge that you have read and understand all the information contained in our office policies. You also agree that any outstanding debt to our office will not be included in any bankruptcy petition.

_____ _____

Patient Signature / Legally Authorize Representative Date

_____ _____

Patients Printed Name Relationship to Patient

13 NE 5th Avenue, Milton-Freewater, OR 97862 541-938-0400 www.4SeasonsDentalMF.com info@4SeasonsDentalMF.com

HIPAA NOTICE OF PRIVACY PRACTICES

4 Seasons Dental / Todd Schroeder, DDS
13 NE 5th Avenue, Milton-Freewater, OR 97862 ♦ 541-938-0400
Effective January 8, 2015

We are obligated by law to give you our Notice of Privacy Practices. This notice describes how your health information may be used, disclosed, and accessed as well as how we protect it and what your rights are regarding it. We respect our legal obligation to keep health information that identifies you private.

Treatment, Payment, and Health Care Operations

The most common reason we use or disclose your health information is for treatment, payment, or health care operations. Examples of disclosure of information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and communicating the prescription; referring you to another doctor for health care or services; or getting copies of your health information from another professional. Examples of how we use or disclose your health information for payment: preparing and sending bills or claims, and collecting unpaid amounts either through our office or through a collection agency or attorney. "Health care operations" mean any administrative and managerial functions used in running our office. Examples of this are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without special permission. If we need to disclose your health information outside of our office for these purposes, we generally do not ask you for written permission.

Uses and Disclosures for Other Reasons Without Permission

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us. Some may never occur at our office at all. Such uses or disclosures are 1) when a state or federal law mandates that certain health information be reported for a specific purpose 2) for public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices 3) disclosures to governmental authorities and victims of suspected abuse, neglect or domestic violence 4) uses and disclosure for health oversight activities, such as the licensing of doctors, for audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws 5) disclosure for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies 6) disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else 7) disclosure to a medical examiner to identify a dead person or to determine the cause of death, or to funeral directors to aid in burial, or to organizations that handle organ and tissue donations 8) uses or disclosures for health related research 9) uses and disclosures to prevent a serious threat to health or safety 10) uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials, for lawful national intelligence activities, for military proposes, or for the evaluation and health of members of the foreign service 11) disclosure of de-identified information 12) disclosure relating to worker's compensation programs 13) disclosures of a "limited data set" for research, public health, or health care operations 14) incidental disclosures that are an unavoidable by-product of permitted uses or disclosers 15) disclosure to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

Appointment Reminders

We may communicate with you (call, text, email, or mail) to remind you of a scheduled appointment or that it is time to make a routine appointment. We may also communicate to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may mail you a reminder and/or leave you a reminder message on your home answering machine or with someone there if you are not home.

Other Uses and Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. We may initiate the authorization process if the use or disclosure is something we need. You may initiate the process if it's your wish for us to send your information to someone else. We need a properly completed authorization form either from our office or the receiving office to send information. If we initiate the process, you do not have to sign the authorization. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing and sent to the office address listed above.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment, or health care operation. We do not have to agree to this, but if we do, we must honor your restrictions. To ask for a restriction, send a written request to the office address at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using a personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. To ask for confidential communications, send a written request to the office address at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are some situations in which we can refuse to permit access or copying, but generally, you will be able to review or have a copy of your health information within 30 days of the request (or 60 days if the information is stored off-site). You may need to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of time to give you access or photocopies if we send you a written notice. If you want to review or get photocopies of your health information, send a written request to the office address at the beginning of this Notice.
- Ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received incorrect information, and others that you specify. If we don't agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will include it whenever we make a permitted disclosure of your health information. By law, we have one 30 day extension of time to consider a request for amendment if we notify you in writing. If you want to ask us to amend your health information, send a written request to the office address at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (shorter period if you would like). By law, the list will not include: disclosures for purposes of treatment, payment, or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one list per year without charge. If you want more frequent lists, you will need to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we have one 30 day extension if we notify you in writing. If you want a list, send a written request to the office address at the beginning of this Notice.
- Get additional paper copies of this HIPAA Notice of Privacy Practices upon request, even if previous copies were received. If you want additional paper copies, send a written request to the office address at the beginning of this Notice.

Our HIPAA Notice of Privacy Practices

By law, we must abide by the terms of this HIPAA Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your past health information as well as to information generated in the future. If we changed, we will post the new Notice in our office, have copies available in the office, and post it on our website.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send or deliver a written complaint to the office address at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

I acknowledge that I have read and understand this HIPAA NOTICE OF PRIVACY PRACTICES for 4 Seasons Dental.

Name:_____ Signature:_____ Date:_____