
# Patient Information

Patient name: First _____ MI __Last _____ Birthdate__/__/____

Address _____ City_____ State___ Zip _____

Home phone _____ Cell phone _____ Work phone_____

Email address _____

*Providing cell phone number and email you will receive information re: appointments via text messaging and email.* (Please circle one)
***YES, I want to have this service/ NO, I do not want this service***.

## Responsible Party Information

**Account Holder:** First _____ MI_____ Last name_____
*Account holder is the person responsible for the payment of services rendered. All family members will be on one account. Unless otherwise specified.*

***SSN*: _____-_____-_____ (*Required for Account Holder/Parent/Guardian*)**

Date of birth: ____/____/_____

Address _____ City _____ State ____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Emergency and Nearest relative contact name and phone _____

How did you hear about us: ☐ Newspaper ☐ Radio ☐ TV ☐ Internet ☐ Friend_____

Signature _____ Date _____

**PRIMARY DENTAL INSURANCE**

Subscriber name: First _____MI ____Last _____

Subscriber ID#:_____ Subscriber date of birth: _____-____-_____

Insurance company: _____

Insurance group number: _____ Insurance phone: _____

Employer: _____

**SECONDARY DENTAL INSURANCE**

Subscriber name: First _____MI ____Last _____

Subscriber ID#:_____ Subscriber date of birth: _____-____-_____

Insurance company: _____

Insurance group number: _____ Insurance phone: _____

Employer: _____

***Medical insurance applies only for Sleep Medicine patients and Medical benefit with embedded pediatric policy.***

**Medical Insurance – Primary**

Subscriber name: First _____MI ____Last _____

Subscriber ID#:_____ Subscriber date of birth: _____-____-_____

Insurance company: _____

Insurance group number: _____ Insurance phone: _____

Employer: _____

**Medical Insurance – Secondary**

Subscriber name: First _____MI ____Last _____

Subscriber ID#:_____ Subscriber date of birth: _____-____-_____

Insurance company: _____

Insurance group number: _____ Insurance phone: _____

Employer: _____



# Dr. David Willis, DMD

631 Jason Street NE, Suite 150
Salem OR, 97301
503-364-3004
www.willisdental.net


## Financial Agreement and Policies

The following are the terms and conditions hereinafter ("Agreement") governing all amounts owing to Willis Dental, David G. Willis, DMD, LLC an Oregon Limited Liability Company, as creditor, from the Patient/Debtor and/or Responsible Party signing below. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor and/or Responsible Party. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to David G. Willis DMD, Willis Dental. By signing below, you are agreeing to pay for all services that are received as required under this Agreement. By signing below you are acknowledging that all of the information provided to us is complete and accurate

**All charges you incur are your responsibility regardless of your insurance coverage.**

***************Insurance coverage*** is a valuable asset in restoring and maintaining good health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. We may also be able to determine benefits prior to treatment, which provides you with important deductible and co-payment information. Our office is not a part of that contract and the final responsibility of payment is yours. As a courtesy to you, we will process your insurance claims. If there is no payment from the insurance company within sixty (60) days, you will be expected to pay the balance in full.

***************Your portion of the payment*** **is due at the time of services rendered.** We accept cash, money orders, and personal checks, Visa, Master Card, Discover, American Express and Care Credit. There is a fee for returned checks by the bank. The current fee is $30.00. One and one-half percent (1.5%) per month interest (18% annually) will be charged on accounts 90 days from the treatment date.
NOTE: If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and collections costs.

***************All missed and cancelled appointments*** **with less that a 24-hour notice**, the 1st time will be allowed to reschedule. A 2nd missed appointment the patient will receive a warning. A 3rd missed or cancelled appointment with less than 24 hours, the patient, guarantor on account will be required to pay a down payment of $75, paid by credit card at the time of rescheduling of their dental appointment. This is non-negotiable and will only be refunded with a $0 account balance after treatment completed or insurance benefits have been received. Willis Dental reserves the right to dismiss a patient and family members on the same account who do not comply to these guidelines.

**I have read the above statement of the Financial Agreement and Policies, and understand that regardless of any insurance coverage I may have, I am responsible for the payment of my account.**

Signature_____Date:_____

# Medical History

**Name**_____**Birthdate**_____

**Primary Care Physician**_____**Telephone**_____

**Address**_____ **Date of last physical**_____

**Do you require antibiotics prior or dental treatment?** ____ Yes ____ No

**Have you had an adverse reaction to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication?**

____ Yes ____ No Please list

_____

**Are you taking or have you taken Bisphosphonates such as Fosamax, Actonel, Boniva, Zometa or Aredia?** ___ Yes ___ No

***Do you presently have OR have a history of:**

___ Alcoholism
___ Allergies (seasonal)
___ Alzheimer's, dementia, memory loss
___ Angina Pectoris (chest pain)
___ Arthritis
___ Artificial heart valve
___ Artificial joints (i.e. hip, knee)
___ Asthma / Breathing problems
___ Back problems
___ Blood transfusion
___ Cancer
___ Chemotherapy or radiation
___ Cortisone or steroid therapy
___ Depression
___ Dental anxiety
___ Diabetes (type 1 or type 2)
___ Drug addiction
___ Epilepsy or seizures
___ Excessive bleeding
___ Fainting or dizzy spells
___ Glaucoma
___ Headaches
___ Heart murmur
___ Heart problem or recent heart surgery
___ Hepatitis
___ High / Low blood pressure
___ High cholesterol
___ HIV positive / AIDS
___ Immune deficiency
___ Kidney disease
___ Liver disease
___ Lung disease
___ Mitral valve prolapse
___ Mouth sores or growths
___ Pacemaker
___ Parkinson's disease
___ Psychiatric care
___ Respiratory disease
___ Rheumatic fever
___ Sinus problems
___ Skin rash
___ Snoring/Sleep disorder
___ Stomach problems (i.e. acid reflux)
___ Stroke
___ Teeth grinding or clenching
___ Thyroid disease
___ TMJ pain (pain in jaw)
___ Tobacco use (i.e. smoke or smokeless)
___ Tonsillitis
___ Tuberculosis
___ Venereal disease
___ Other

**Office Use Only**

**(Women)** Could you be pregnant? ___ Yes ___ No, Breastfeeding? ___ Yes ___ No, Are you taking birth control? ___ Yes ___ No

**Signature** _____ **Date** _____

**Patient Name** _____

**Current Medications**

| Medication Name | Dose/Frequency | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medical History Update**

| Date | Change in medical history or medication | Patient Initial | Provider Initial |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Willis Dental**
**Sleep Assessment**

Name: _____ DOB: _____ Date: _____

Y / N Have you ever been diagnosed with a sleep disorder (sleep apnea)?
Y / N Is a Sleep Medicine physician treating your sleep disorder? Name of doctor_____.
Y / N Do you currently use a CPAP machine?
Y / N Do you use it every night?

If you answered no, please complete form.

This questionnaire was developed based upon the published finding of the American Academy of Sleep Medicine (AASM). 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.

Please circle Y-yes or N-no, if yes the number is applied to the Score and Risk Factor total.

Y / N -8- Have ever been told you stop breathing while asleep?

Y / N -6- Have you ever fallen asleep or nodded off while driving?

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 a 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 and Risk Factor total_____

Low: 0-7, Moderate: 8-11, High: 12-15, Severe: 16+

*Willis Dental*
*631 Jason Street NE, Suite 150*
*Salem, Oregon 97301*
*503-364-3004*

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the top of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1 for each page, $25 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Willis Dental**
**631 Jason Street Ne, Suite 150**
**Salem, OR 97301**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this office's

Notice of Privacy Practices. Date received: _____.

_____
Print Name

_____
Signature

I give permission for ***Willis Dental*** to share my health and account information with the person(s) listed:

_____

_____

---

**For Office Use Only**

---

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify)