

WELCOME
StudioNine30
Dr. Matt Engel

Personal Information

Patient's Name _____ Date _____

Birth Date _____ Social Security Number _____ Marital Status _____

Street Address _____ City _____ State _____ Zipcode _____

Mailing Address(if different) _____ City _____ State _____ Zipcode _____

Home Phone _____ Cellular Phone _____ email _____

Employer _____ Work Phone# _____

Name of Spouse/Parent (if applicable) _____

Spouse/Parent Birth Date _____ Spouse/Parent SS# _____

Spouse/Parent Employer _____ Work Phone# _____

Emergency Contact and Phone # _____

How did you hear about us? A friend or a family member? The Bulletin? Yellow Pages? _____

Dental Insurance Information

Primary Insurance Carrier _____ Group # _____

Name of Subscriber _____ ID# _____

Insurance Address/City/State/Zip _____ Insurance Phone# _____

- Please be sure to inform the business office of any insurance changes. As a courtesy our office will follow through on all outstanding claims up to 90 days from the original date of service. Your assistance is appreciated to expedite the handling of your dental reimbursement plan.

Consent for Dental Insurance Filing

I authorize the release of necessary records to the insurance company of record to secure payment of benefit. I am financially responsible for the estimated patient portion at the time of service and all charges whether or not paid by insurance. All charges over 60days are subject to finance charges of 18% annually.

Signature _____ Date _____

Health History

**Have you ever had or are you currently being treated for any of the following?
Please circle all that apply:**

AIDS/HIV	Depression	Heart Attack	Pace Maker
Anemia	Diabetes	Valve Replacement	Pregnant:Due Date:____
Anxiety Attacks	Epilepsy	Hepatitis: A B C D	Respiratory Problems
Arthritis	Fainting	High/Low Blood Pressure	Rheumatic Fever
Artificial Joints	Glaucoma	Jaundice	Sinus Problems
Asthma	Hay Fever	Joint Replacement	Stomach Problems
Blood Disease	Head Injuries	Kidney Disease	Stroke
Cancer/Radiation	Heart Murmur	Liver Disease	Tumors

Codeine Allergy Erythromycin Allergy Sulfa Allergy
 Penicillin Allergy Latex Allergy Other_____

Are you currently taking any medications including birth control pills, aspirin, coumadin or holistic remedies?

If yes please list:_____

Have you ever been hospitalized or do you have any health problems that need further clarification?

If yes, please explain:_____

Are you currently using tobacco? Yes/No if yes, length of years used:_____ times per day_____
Have you ever used any form of tobacco? Yes/No if yes, cigarettes/cigars/chewing tobacco

Have you ever been in a car accident? Yes/No When?_____

Do you have any neck injuries? Yes/No When?_____

Do you suffer from any chronic back or neck problems? Yes/No How Long_____

Do you sleep deeply at night? Yes/No

Have you ever been told you grind your teeth at night? Yes/No

When you awake in the morning do you find you have headaches or tired jaw muscles? Yes/No

Do you sleep mostly on the Back? Stomach? Or Side?

Dental and Oral Hygiene History

Reason for today's visit?_____

Have you ever been treated for any of the following?

Periodontal disease, When?_____ Root plaining and scaling, When?_____

Tissue grafting or surgery, When?_____ TMJ Pain, When?_____

Orthodontics/Invisalign, When?_____

When was your last dental visit?_____ When was your last hygiene(cleaning)visit_____

What do you use in the care of your teeth? Manual TB, Mechanical TB, Floss, Perio Aids, Rinses? (please circle all that apply)

How many times per day do you brush your teeth?_____ How frequently do you floss?_____

Do you experience any of the following?

- Food Trapped? Floss Shredding? Bleeding or swollen gums?
- Bad breath or bad taste in your mouth? Metallic Taste? Chipped teeth?

Do you chew gum everyday? Yes/No
 Does your bite feel even, can you bite comfortably on both sides at once? Yes/No

On a scale of 1-10 with 10 being the highest rating:

How important in your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Are you happy with your smile? Yes/No

If you could change anything about your smile, what would it be? _____

Consent for Services

To the best of my knowledge, all the information provided is true and correct. If I ever have any change in my health, I will inform the provider at the next appointment that I am scheduled. I am financially responsible for all charges. Payment is due at time of service>

Signature _____ Date _____

Acknowledgement of receipt of Notice of Privacy Practices

Purpose of Consent: By signing this form you are giving consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you sign this consent. We encourage you to read it carefully and completely before signing.

◆ You may refuse to sign this Acknowledgement ◆

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

If this consent form is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Patient _____

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of the consent will not affect any action we took prior to the written consent.

You may obtain a copy of our Notice of Privacy Practices including any revisions at any time by contacting:

The Business Office of Dr. Matthew B. Engel Phone: 541.317.9381
 930 SW Yates Drive Fax: 541.317.5038
 Bend, OR 97702

