

# OREGON MOBILE DENTISTRY

## Patient Information

Patient Name: \_\_\_\_\_  
LAST FIRST MI PREFERRED NAME

Date of Birth: \_\_\_\_\_ Sex: Male Female Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

Facility Name (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Contact Information

Guardian/Power of Attorney/Other: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
(NAME)

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY STATE ZIP

## Dental Insurance Information

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Group number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Subscriber Name (if different than patient name): \_\_\_\_\_ Subscriber Birthday: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian/Patient/Power of Attorney

OREGON MOBILE DENTISTRY  
11820 SW KING JAMES PLACE, SUITE 10J  
TIGARD, OR 97224  
503-616-5000  
503-765-7674 FAX  
[oregonmobiledentistry@gmail.com](mailto:oregonmobiledentistry@gmail.com)

## Financial Policy

We share your concern regarding the increasing cost of health care. We believe that you/your family members expect and deserve the highest quality of care we can provide. We take advantage of every possible avenue to keep costs down and are committed to providing affordable care without sacrificing quality. In order to prevent any misunderstandings, we invite you to consult with us if you have any questions regarding our services and our policies.

Patients are often under the impression that if they have dental insurance, it is the insurance company who owes the doctor for his services. This is not so. *Your insurance contract is between you and the insurance company. Therefore, you are responsible for the bill for dental services, regardless of insurance coverage determination.* As a courtesy to our patients, we bill the insurance company directly. Many insurance plans cover less than 100% of actual costs—typically 50% to 80%. To further limit liability, many plans cover even less by establishing Usual and Customary Rates (UCR's). Their determination of UCR's may or may not have any relation to the rates established by our office. At your request we can receive a pre-authorization of coverage from your carrier. This usually requires three to four weeks to be processed by the insurance company.

Payment for service is due upon receipt of statement sent out the beginning of each month. Dental insurance will be billed for our patients as a courtesy, and a statement will be sent after the insurance has been billed. All accounts over 90 days are subject to a \$5.00 monthly rebilling charge.

By signing this form, you will consent to our use and disclosure of your protected health information to carryout treatment, payment activities, and healthcare operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Medical History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for appointment: \_\_\_\_\_

In addition to the exam and x-rays, what services would you like done during first appointment: (please check boxes)

Cleaning \_\_\_\_\_ Fillings \_\_\_\_\_ Extraction \_\_\_\_\_ Other: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

(This information is necessary as medical records will be requested from your PCP prior to dental appointment).

Please list medications: \_\_\_\_\_

Please list allergies: \_\_\_\_\_

For Diabetic patients, what is your A1C level? \_\_\_\_\_ When was it last taken? \_\_\_\_\_

Have you ever had a joint replacement? Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Phone: \_\_\_\_\_

Do you require an antibiotic prior to dental appointment? Yes \_\_\_ No \_\_\_ Reason: \_\_\_\_\_

Diagnosed with oral cancer? Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_ Heart valve replacement? Yes \_\_\_ No \_\_\_

Date: \_\_\_\_\_

History of bisphosphonates? (Oral or IV)? Yes \_\_\_ No \_\_\_ If yes, since when? \_\_\_\_\_

Please enter any additional health concerns: \_\_\_\_\_

Code status: DNR \_\_\_\_\_ DNI \_\_\_\_\_ Full code \_\_\_\_\_ CPR \_\_\_\_\_

Please put a X next to any of the following that apply and explain below:

AIDS/HIV \_\_\_\_\_ Anxiety/Nervous Disorder \_\_\_\_\_ Alzheimer \_\_\_\_\_ Depression \_\_\_\_\_ Diabetes \_\_\_\_\_ Chronic

pain \_\_\_\_\_ COPD \_\_\_\_\_ Respiratory Disease \_\_\_\_\_ Low Blood Pressure \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Congestive Heart

Failure \_\_\_\_\_ Respiratory Disease \_\_\_\_\_ Blindness \_\_\_\_\_ Hearing Loss \_\_\_\_\_ Seizures \_\_\_\_\_ Sudden Weight Loss \_\_\_\_\_

Parkinson \_\_\_\_\_ Headache \_\_\_\_\_ Oxygen use \_\_\_\_\_ Hepatitis \_\_\_\_\_ If yes, what kind \_\_\_\_\_ Date diagnosed \_\_\_\_\_

Cancer \_\_\_\_\_ If so, what kind \_\_\_\_\_ Date diagnosed \_\_\_\_\_ Autoimmune

Disorder \_\_\_\_\_ Other: \_\_\_\_\_

I certify that above information about my medical history is accurate. I authorize and give consent for my dentist to perform dental services agreed upon as well as discuss dental care with my PCP.

X \_\_\_\_\_

GUARDIAN/PATIENT/POWER OF ATTORNEY

SIGNATURE

DATE



11820 SW King James Place Suite#10J Tigard, OR. 97224  
oregonmobiledentistry@gmail.com  
Phone 503-616-5000  
Fax 503-765-7674

The first visit by the Oregon Mobile Dentistry team includes:

- Travel/Staff time
- Equipment
- Comprehensive exam
- X-Rays
- Treatment plan

The cost of the first visit is \$600.00 (plus the cost of any additional service provided). For each additional appointment needed, the fee is reduced to \$300.00 (plus the cost of any additional service provided).

As a courtesy to the patient, a dental claim can be sent to a dental insurance company. **This does not guarantee payment from the insurance company.** The patient/POA is responsible for paying for dental services provided.

If your treatment plan changes after the doctor completes the exam and reviews the x-rays, the patient may give verbal consent to do additional treatment. The patient/responsible party is responsible for the difference in the remaining balance. By signing below, you agree that you understand all costs are the best estimate we can provide based on the information given to us at the time the appointment was scheduled. All unpaid balances are subject to late charges as well as further collection action if the balance is not paid in a timely manner.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Oregon Mobile Dentistry, PC

## Privacy Policy and Information Practices Patient Rights Statement Use and disclosure of Health Information Consent Form

Consent: By signing this form, you do consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office Privacy Policy and Information Sharing Policy.

Right to revoke: You have the right to revoke this consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this consent.

Changes to Privacy Practices: We reserve the right to change our privacy practices described in our Patients' Rights Privacy Policy and Information Practice statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to, health history information, address, telephone number, active insurance policy, and change in employer.

I, \_\_\_\_\_,  
Please Print Name

Have received a copy of Oregon Mobile Dentistry's Privacy Policy and Information Practices. I have read and understand the above information. I understand that by signing this form I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consenting Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



RELEASE AUTHORIZATION FOR PATIENT RECORDS  
TO  
OREGON MOBILE DENTISTRY  
11820 SW KING JAMES PLACE, SUITE 10J  
TIGARD, OR 97224  
TEL (503) 616-5000 FAX (503) 765-7674

I hereby authorize and request that \_\_\_\_\_ release the medical records (diagnosis, medications & allergies) of the below named patient from Oregon Mobile Dentistry to this email: [Oregonmobiledentistry@gmail.com](mailto:Oregonmobiledentistry@gmail.com)  
Or fax to 503-765-7674.

By signing this form, you are consenting to the transfer of protected health information to the healthcare provider identified above.  
You have the right to read our Notice of Privacy Practices before you decide to sign this consent.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian/POA: \_\_\_\_\_ Telephone: \_\_\_\_\_

By signing this form, I am giving consent to the transfer of protected health information to/from Oregon Mobile Dentistry.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Dental Procedure Information Sheet

---

## Purpose of this Document

This document provides detailed information about common dental procedures that **may be** necessary for you or your family member, including periodontal procedures/cleanings, fillings, and extractions. It serves as a reference on the benefits, details of the procedures, alternatives, and potential risks. Once the specific dental needs and treatment plan are determined, we will contact you to discuss the options and any associated costs, giving you the opportunity to consent or decline at that time. Please keep this document for your reference in case these procedures become necessary in the future.

---

## Periodontal Procedures

### Debridement

Debridement is an intensive cleaning procedure used to remove heavy plaque and tartar build-up from above and below the gum line, often necessary before a thorough periodontal evaluation. After debridement, a prophy or SRP (see below) will be needed to refine the cleaning process once the gums have had some time to heal.

### Prophylaxis (Prophy)

Prophylaxis, or a routine dental cleaning, involves removing plaque, tartar, and surface stains from teeth above the gum line. It is a preventive measure to maintain oral health and prevent periodontal disease.

### Scaling and Root Planing (SRP)

Scaling and root planing is a deep cleaning procedure for treating periodontal disease. It involves removing plaque and tartar from below the gum line (scaling) and smoothing the root surfaces (root planing) to help gums reattach to teeth. This sometimes requires anesthetic administration and often requires multiple visits.

### **Periodontal Maintenance**

Periodontal maintenance is an ongoing treatment for patients who have had periodontal therapy, and typically exposed roots and/or deep pockets. It involves regular, thorough cleanings to remove plaque and tartar and monitor gum health to prevent disease recurrence.

### **Possible complications of treatment include:**

- Temporary gum irritation or discomfort
- Minor bleeding during or after the procedure
- Increased tooth sensitivity
- Potential for infection if aftercare instructions are not followed

### **The consequences of doing nothing or not completing treatment may include:**

- Progression of periodontal disease, leading to deeper gum pockets
- Increased risk of tooth loss due to untreated gum disease
- Persistent bad breath and oral discomfort
- Greater potential for systemic health issues related to untreated periodontal disease, such as heart disease and diabetes complications

---

### **Fillings**

Fillings are a routine dental procedure used to restore decayed or broken teeth in order to restore the tooth's function, shape, and strength. During the procedure, the dentist removes any decayed tooth structure and fills the resulting space. Common filling materials include glass ionomer and composite, which are white,

while silver amalgam fillings are occasionally used as well. Teeth are numbed with local anesthetic when necessary to improve patient comfort.

**Possible complications of treatment include:**

- If the cavity is larger than expected, the tooth may need further treatment, such as a root canal, crown, or extraction.
- Sensitivity to hot and cold
- Potential for filling to fall out or need replacement due to future decay
- Reactions to local anesthetic or the stress of the procedure

**The consequences of doing nothing or not completing treatment may include:**

- Progression of decay, leading to further damage to the tooth structure
- Increased risk of tooth sensitivity and pain
- Potential for infection or abscess formation
- Risk of eventual tooth loss if decay advances unchecked

**Alternative treatments may include:**

- A dental crown, which covers the entire tooth
- Monitoring minor decay for progression
- In some cases, silver diamine fluoride can be applied to slow the progression of decay

---

## **Tooth Extractions**

Tooth extraction is a dental procedure in which a tooth is removed from its socket in the jawbone. This may be necessary due to severe decay, periodontal disease, infection, or trauma, or to allow the fabrication of an appliance such as dentures or partials. Before the extraction, the dentist will administer local anesthesia to numb the area and may use special instruments to loosen the tooth from the socket before carefully removing it. The procedure may also require incisions on the gums, cutting the tooth, or removal of the bone around the tooth. After the

procedure, the dentist will clean the socket and may place sutures and/or materials to help a blood clot form.

**Possible complications of treatment include:**

- Infection
- Prolonged bleeding, bruising, and swelling
- Dry socket, a painful condition caused by loss of the blood clot
- Damage to adjacent teeth or surrounding bone
- Problems with healing, especially in patients with a history of radiation to the head and neck or previous use of bisphosphonate medications (please inform us of this applies to you)
- Damage to nerves resulting in temporary or permanent numbness
- Sinus involvement which may require surgical repair
- Reactions to local anesthetic or the stress of the procedure

**The consequences of doing nothing or not completing treatment may include:**

- Progression of decay, leading to infection or abscess formation
- Increased risk of tooth sensitivity and pain
- Loss of surrounding teeth

**Alternative treatments may include:**

- In some cases, a tooth may be able to be restored with a root canal or crown
- In some cases, silver diamine fluoride can be applied to slow the progression of decay
- No treatment

---

**Questions?**

The information above is general and may not apply to your/your family member's specific situation. If you have questions, we are here to help. Please

contact our office if you have any questions or concerns about these procedures or any other aspect of your family member's dental care.