Welcome to Aesthetic Dentistry of Lake Oswego

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Email: DrBowden@LakeOswegoSmiles.com Website: www.aestheticdentistryoflakeoswego.com

Guest Registration

Last Name:_____First:_____M.I.:_____

Preferred Name:_____Birth Date:_____Male/Female:_____

Home Phone:_____Cell:_____Work:_____

Address:_____City: _____St.:_____Zip:_____

Email:_____ SS#:_____

Responsible Party: _____Phone#:_____

Address:_____City: _____ St.: _____Zip:_____

SS#:_____ Birth Date:_____ Relationship to Patient:_____

Employer:_____ Insurance Company:_____ Group #:_____

Person to contact for Emergency:_____Phone#:_____

How did you hear about us?_____

Consent for Treatment

* I hereby authorize Dr. Bowden or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor so that he can make a thorough diagnosis of my dental needs and that these records may be used for diagnostic purposes, educational purposes, and research. I hereby give my consent for my records to be used for these purposes.

* Upon such diagnosis, I authorize Dr. Bowden to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

* I agree to the use of anesthetics, sedatives, and medications as necessary. I fully understand that using anesthetic agents, medications, dental materials, and treatment procedures embodies certain risks. I understand that I can ask for a complete recital of any complications.

* All health questions are answered to the best of my knowledge. I will notify Dr. Bowden of any change in my health, and my health provider or agency may release information to you.

* I acknowledge receipt of the Notice of Privacy Practices.

* I agree to be responsible for payment of all services at the time of service. In the event payment is not received as agreed, I understand that a 1.5% late charge per month may be added to my account.

*Patient/Parent Signature:*_____*Date:*_____

Time 8:25 AM | Aesthetic Dentistry Of Lake Oswego | Date 3/5/2019

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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
Are you taking any Vitamins or Supplements?	◯ 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	Autism ◯ 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	Lyme Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No	Hashimoto's Disease ◯ Yes ◯ No	Fibromyalgia ◯ 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:_____

Dental History

*Name:*_____ *Birth Date:*_____ *Date:*_____

Previous Dental Office:_____ Doctors Name:_____

Address:_____City:_____St:_____Zip:_____

Telephone Number:_____ Last Dental Cleaning:_____Last Visit:_____

Last Eye Exam:_____Last Full Mouth X-rays:_____May We Request These X-rays? **YES** **NO**

How Often Do You Have Dental Examinations?:_____Do You Prefer Fluoride Free Products?: **YES** **NO**

How Often Do You Brush Your Teeth?:_____Floss?:_____

What Dental Aids Do You Use?:(Sonicare, Waterpik, Proxy Brush, Toothpicks, etc.)_____

Do You Currently Have…..

Active Dental Problems?	**YES**	**NO**	Gum Disease?	**YES**	**NO**	Trouble with Bad Breath?	**YES**	**NO**
Missing Back Teeth?	**YES**	**NO**	Bleeding Gums?	**YES**	**NO**	Broken Teeth?	**YES**	**NO**
Sensitivity to Sweets?	**YES**	**NO**	Oral Lesions?	**YES**	**NO**	Cold Sores or Blisters?	**YES**	**NO**
Sensitivity to Temperature?	**YES**	**NO**	Decay?	**YES**	**NO**	Jaw Joint Pain?	**YES**	**NO**

Any Loose Teeth? **YES** **NO** If "**YES**", Where?:_____

A Bite Plate or Mouth Guard,etc? **YES** **NO** If "**YES**", Why?:_____

Have You Ever Had…..

Orthodontic Treatment?	**YES**	**NO**	A Broken Jaw?	**YES**	**NO**	Endodontic Treatment?	**YES**	**NO**
General Anesthesia?	**YES**	**NO**	Oral Surgery?	**YES**	**NO**	Periodontal Treatment?	**YES**	**NO**
Teeth Ground/ Bite Adjusted?	**YES**	**NO**	MRI/CT Scans?	**YES**	**NO**	Difficulty Getting Numb?	**YES**	**NO**

Do You Ever…..

Bite Your Cheeks?	**YES**	**NO**	Smoke a Pipe?	**YES**	**NO**	Chew Gum?	**YES**	**NO**
Chew Pens or Pencils?	**YES**	**NO**	Bite Your Nails?	**YES**	**NO**			

Clench or Grind Your Teeth? **YES** **NO** If "**YES**", Morning or Night?:_____

Have you had any injuries to the teeth, mouth, or jaw? **YES** **NO**

If "**YES"**, What Happened and When?: _____

_____

Did any dental related symptoms occur after this accident, injury, or possibly an illness? **YES** **NO**

If "**YES"**, What Are Your Symptoms?:_____

_____

When you bite down, do your teeth hit in the front first? **YES** **NO**

Do you drink alcoholic beverages? **YES** **NO** If "**YES**", How Much and Often?:_____

Do you use Marijuana? **YES** **NO** If "**YES**", How Much and Often?:_____

*What's something you love about your smile?*_____

*What's something you would change about your smile?*_____

Informed Consent

*Name:*_____*Birth Date:*_____*Date:*_____

Confidentiality Statement:

All information shared in your treatment plan is confidential except in circumstances governed by law. If you would like Aesthetic Dentistry of Lake Oswego to confer with another family member or friend, you will need to sign a "Release of Information" form. This permission can be revoked by you at any time.

Financial Agreement:

Your fee per visit is payable at the time of treatment. We accept cash, check, cashier's checks, Visa, Mastercard, American Express, and Discover. We also accept Care Credit and Affirm, if you would like to apply for either of those outside financing options, we will assist you with that. **We do not accept insurance**.

Financial Policy:

If you have insurance that provides coverage for this provider and your treatment, we would be happy to provide you with all necessary documentation to be able to submit a claim yourself for reimbursement. You are responsible for the full fee at the time of service.

If your appointment is scheduled for two or more hours we require 50% of the appointment total at the time of scheduling.

Your Payment is to be Paid in Full at the Time of Service

No-Show and Cancellation Policy:

Your visit has been reserved for you. 24 hours notice (48 hours for any appointment 2 hours or longer) is required for cancellation or you will be charged a late cancellation fee of **$83.00** per hour scheduled.

Emergencies:

If you are experiencing a true dental emergency Dr. Bowden can be reached at the emergency telephone number that is provided on our voicemail recording.

Statement of Understanding:

I have read and understand this information sheet and informed consent.

_____ _____

Patient/Parent or Guardians Signature Date

Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such life style risk factors.** Studies also suggest that human papillomavirus (HPV) plays a roll in more than 20% of oral cancer causes. * Oral cancer risk by patient profile as follows:

Increased risk:	patients ages 18-39 -sexually active patients (HPV)
High risk:	patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)
Highest risk:	patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated VELscope powered by Sapphire into our oral screening standard of care. We find that using VELscope powered by Sapphire along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope Powered by Sapphire, along with the doctor's visual exam, is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. VELscope powered by Sapphire is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope powered by Sapphire exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is NO CHARGE.

❒ Yes. I would prefer to have the VELscope powered by Sapphire exam at this time.

❒ No. I would prefer not to have the VELscope powered by Sapphire exam at this time.

Print Name _____

Signature _____ Date _____

VELscope® powered by Sapphire®

Aesthetic Dentistry

Dr. Larry Bowden — Holistic Dental Care

of Lake Oswego

Consent from Patient to Release Dental Records

I request the release of dental records from the office of:

_____

_____

_____

To be sent to the office of:

Dr. Larry Bowden

Aesthetic Dentistry of Lake Oswego

17437 SW Boones Ferry Road Suite 200

Lake Oswego, OR. 97027

Phone: *503-675-7300*

Fax: *503-675-7305*

drbowden@lakeoswegosmiles.com

Patient Name Printed:_____ ***Date:***_____

_____

Signature of Patient or Legal Guardian