PATIENT INFORMATION

Today's Date _____

Name: _____ Nickname: _____
Last First MI

Birthdate: _____/_____/_____ Gender: Male/Female Social Security Number: _____/_____/_____

_____Minor _____Single _____Married _____Divorced _____Widowed _____ Separated _____Domestic Partner

Driver License No.: _____If you are a student, name of school: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City: _____State: _____ Zip:_____ Cell Phone: _____

Phone Number to Confirm Appts (Home Work Cell)
Please circle

Email address: _____

May we leave a detailed message for you at the above numbers? _____ Yes _____No

How do you wish for us to confirm your appointments? Email Cell Phone Home Phone Work Phone
(Please circle)

Employer Name: _____ Occupation: _____

Person to contact (not living with you) in case of emergency_____Phone_____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

phone book yellow page ad friend/co-worker advertisement dental office web site

RESPONSIBLE PARTY
PARENT OR SPOUSE/PARTNER INFORMATION

Name of person responsible for this account: _____

Relationship to patient: _____ Home Phone: _____

Address: _____

City: _____State: _____Zip: _____

Birth Date: _____/_____/_____Social Security No: _____/_____/_____Drivers License No: _____

INSURANCE INFORMATION

We accept most dental insurance. Due to contract agreements between your employer and coverage provided to you, please be aware of your provider options. We are happy to bill your insurance company as a courtesy to you. We ask that you provide accurate and complete information needed at the time of your appointment. **Please understand that regardless of insurance compensation, you are responsible for the balance on your account.** We ask that you pay your estimated portion of the balance at the time of your visit. We will provide estimates as accurately as possible. However, please understand that these are only estimates.

PRIMARY	SECONDARY
Subscriber's Name:_____ Birth date: _____/_____/_____ ID Number:_____ Name of Insurance Co: _____ Phone No: _____ Group No:_____Effective Date: _____	Subscriber's Name:_____ Birth date: _____/_____/_____ ID Number:_____ Name of Insurance Co: _____ Phone No: _____ Group No:_____Effective Date: _____

Southwest Hills Dentistry LLC

Medical History 5.21.14

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	

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

Women: Are you...

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

Men: Are you...

taking any erectile dysfunction medicati Yes No

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

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Arthritis/Gout
Epilepsy or Seizures	High Cholesterol	Scarlet Fever	Artificial Heart Valve
Excessive Bleeding	Hives or Rash	Shingles	Artificial Joint
Excessive Thirst	Hypoglycemia	Sickle Cell Disease	Asthma
Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble	Blood Disease
Frequent Cough	Kidney Problems	Blood Transfusion	Frequent Diarrhea
Leukemia	Stomach/Intestinal Disease	Breathing Problems	Frequent Headaches
Liver Disease	Stroke	Bruise Easily	Genital Herpes
Low Blood Pressure	Swelling of Limbs	Cancer	Glaucoma
Lung Disease	Thyroid Disease	Chemotherapy	Hay Fever
Mitral Valve Prolapse	Tonsillitis	Chest Pains	Heart Attack/Failure
Osteoporosis	Tuberculosis	Cold Sores/Fever Blisters	Heart Murmur
Pain in Jaw Joints	Tumors or Growths	Congenital Heart Disorder	Heart Pacemaker
Parathyroid Disease	Ulcers	Convulsions	Heart Trouble/Disease
Psychiatric Care	Venereal Disease	Yellow Jaundice	Sleep Apnea

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:_____

Southwest Hills Dentistry, LLC
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Southwest Hills Dentistry, LLC ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Southwest Hills Dentistry, LLC's Privacy Official at:

Office Manager
2350 SW Multnomah Blvd, Suite F
Portland, OR 97219
(503) 246-7109
(503) 244-9928
Info@swhillsdentistry.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on January 1st, 2019.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is January, 1st 2019.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Southwest Hills Dentistry, LLC

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

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

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

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

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

_____
_____
_____

Southwest Hills Dentistry, LLC
2350 SW Multnomah Boulevard
Portland, OR 97219
(503) 246-7109
Info@swhillsdentistry.com

Agreement and Consent

1. I authorize and give consent to the doctor and the staff to administer treatment, including, but not limited to local anesthesia, analgesia, x-rays, photographs and any other treatment that in their judgment, may be necessary for dental health. I understand the use of medications, anesthetics and some procedures may embody a certain amount of risk. This may include allergic reactions and/or other reactions/sensitivities. If I am a female using oral contraceptives, I understand that antibiotics or other medications may interfere with the effectiveness of oral contraceptives. It is my responsibility to inform the doctor of any medical or dental conditions or concerns I may have.
2. I understand and agree that all photographs are the sole property of Southwest Hills Dentistry, LLC.
3. Dental treatment can be unpredictable. I acknowledge that no guarantee has been given as to the treatment results that may be obtained.
4. I acknowledge that the Notice of Privacy Practices is available and I have been given a copy upon my request.
5. I grant my permission to Southwest Hills Dentistry, LLC to contact me on my cell phone or on other numbers I have provided to discuss matters related to this consent, my treatment or my account.
6. I hereby authorize Southwest Hills Dentistry, LLC to release any information necessary to process my dental insurance claims. I further authorize a release of information if necessary to refer my case to a specialist.
7. I understand that all responsibility for payment for dental services provided by Southwest Hills Dentistry, LLC for myself or my dependents is entirely mine, due and payable at the time services are rendered unless other arrangements have been made. I understand all deductibles and copays are required at time of service. Any dishonored checks will be assessed a statutory handling and collection fee of $25 plus any bank related charges.
8. I hereby authorize and direct my insurance company to pay any dental benefits due to me directly to Southwest Hills Dentistry, LLC. I understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of this dental office.
9. I understand that appointment times are reserved specifically for me. It is my courtesy to provide 48 hours' notice of any change in regards to scheduled dental appointments. Failure to provide this consideration will result in a $85 charge.

Signature of PATIENT, PARENT OR GUARDIAN: _____

Date: _____

Southwest Hills Dentistry, LLC
2350 SW Multnomah Boulevard
Portland, OR 97219
(503) 246-7109
Info@swhillsdentistry.com

Office Financial Policies

In the interest of good health care practice and to keep our fees from rising, we have established a credit policy to avoid any misunderstanding. The benefits to a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

All accounts are due and payable at the time of your visit. Patients with insurance are expected to pay a portion of the treatment estimated on the day of dental service. Non-insured patients are expected to make payment in full on the day dental services are rendered unless definite arrangements have been made in advance. Cash, checks, Visa, Master Card and Care Credit are accepted. Up to 5% discount is extended for patients that pay at the time of service and an additional 5% discount will be offered to our Honored Citizens (65 years and older) who have no insurance. Patients are liable for all fees connected with returned checks and processing.

Appointments missed or short notice cancellation without 48 hours notice will result in an $85 charge.

As a courtesy, our office will file your claim with your insurance and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow. We are only able to give an estimation of costs toward dental treatment and you are responsible for any costs not covered by insurance. We will assist you in obtaining your dental benefits that are specified in your dental contract by professionally accepted methods. Your insurance contract, however, is between you, your employer and the insurance company. It is important to understand that not all dental services are covered in all insurance contracts. Some insurance companies arbitrarily select certain services that they will not cover. It is dental services are covered in all insurance contracts. It is your responsibility to determine your benefits with your plan. We will aid in the predetermination of your insurance benefits at your request. However, this will delay our ability to provide dental services to you as we wait for your insurance company to respond. After insurance payments have been received, if there is a balance on your account, our office will extend 90 days grace period for you to bring your account current. After the 90 days grace period any balance outstanding will bear interest at 18% per annum or 1.5% per month. These additional fees will be applied to the unpaid balance. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim, therefore, you are responsible for payments to your account. We will only send statements out to those accounts that have balances due. If we are waiting on your insurance payment, you may not receive a bill until we know accurately what insurance will cover.

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payments on my account. I authorize Dr. Hill to collect the payment owed if not paid within my account. I understand that my delinquent account will be assigned to a credit reporting collection service. If it becomes necessary for my account to go to a collection agency, any amount owed on this or subsequent visits, I understand and agree to pay for all costs and expenses including reasonable attorney fees. This will insure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time. All patients on an account that is referred to collections will only be eligible for emergency treatment for 30 days and will be dismissed from the dental practice if the balance is not paid.

I have read the above policies and agree to abide by them.

Signature of PATIENT, PARENT OR GUARDIAN: _____