CENTERPORT
FAMILY & IMPLANT DENTISTRY

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Phone: (503) 228-1506

Welcome Agreement

Welcome to our family of patients. We are delighted you have chosen the Centerport Dental team to provide you with your oral health care. We are committed to providing you with the highest quality dentistry, and look forward to building a partnership to keep you and your smile as healthy as possible.

As a courtesy to you, we gladly process your insurance claims and provide you with an estimate of your co-pay for each visit. Each estimate is based off information given to us by your insurance carrier and is only an estimate. Ultimately you are responsible for any charges not paid by your plan. Please read your insurance benefit booklet and understand all waiting periods, frequency limitations, exceptions, and exclusions. Please know that we do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their portion within 60 days from the start of your treatment, you are responsible for payment at that time.

We ask that if you must cancel a scheduled appointment that you kindly give ***48 hour* notice**. Dr Wang and the entire staff spend valuable preparation time arranging every detail for your visit. With respect to the staff that serves you and other patients who depend on us, we appreciate timely cancellation notifications and alerts if you are running late. If sufficient notice is not received there is a customary fee of $50.00 for a missed hygiene appointment and a $100.00 fee for a missed treatment appointment.

We collect all out of pocket expense in full on the date of service. If you have a financial concern, we are happy to share with you our Care Credit payment plan options. There are no interest options available as well and low interest extended plans designed to fit every budget.

We look forward to getting to know you better through the years to come, and happily welcome you to our practice.

I acknowledge that I understand the information listed above and consent to the welcome agreement. ☐

Signature of patient, parent, or guardian (responsible party):

Signature:_____Date:_____

Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

DENTAL HISTORY

Patient Name_____ Date of Birth_____ Age_____

Referred by How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist How long have you been a patient? Months/Years

Date of most recent dental exam / / Date of most recent x-rays / /

Date of most recent treatment (other than a cleaning) / /

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

		YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed?	☐	☐

GUM AND BONE

		YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

		YES	NO
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT

		YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench your teeth in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐

		YES	NO
33.	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

MEDICAL HISTORY

Patient Name _____

Name of Physician/and their specialty

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. An allergic reaction	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfalocal		
☐ anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver,) latex		
☐ other		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)		
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. emphysema, shortness of breath, sarcoidosis	☐	☐
14. tuberculosis, measles, chicken pox	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c =)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐

	YES	NO
27. arthritis	☐	☐
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
35. any lumps or swelling in the mouth	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI / STD / HPV	☐	☐
38. hepatitis (type)	☐	☐
39. HIV / AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psychiatric treatment	☐	☐
45. antidepressant medication	☐	☐
46. alcohol / recreational drug use	☐	☐
ARE YOU:		
47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. a smoker, smoked previously or use smokeless tobacco	☐	☐
54. considered a touchy / sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant	☐	☐
58. prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient Information:

Address: _____

City, State & Zip: _____

Cell & home phone number: _____

Email: _____

Occupation or Place of work: _____

Patient's Signature _____ **Date** _____

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Health Consent

Section A: Patient Giving Consent:

Name: _____

Section B: To The Patient—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether t o sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, at any time.
Contact Person: Any staff member of Benjamin C. Wang, DMD, PC
Phone: (503) 228-1506 **Fax:** (503) 228-1499
Email: admin@centerportdental.com
Address: 610 SW Alder Street Suite #1105, Portland, OR 97205

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative's Name: _____

Relationship to Patient: _____

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Sleep Apnea Survey

YES NO Do you snore?

YES NO Have you or anyone observed you stop breathing or gasp during sleep?

YES NO Do you wake up tired or fatigued?

YES NO Do you doze off easily?

YES NO Do you ever wake up out of breath, gasping or coughing?

YES NO Are you a restless sleeper?

YES NO Do you ever have indigestion or acid reflux?

YES NO Do you have headaches or jaw pain?

YES NO Do you have or ever had in the past high blood pressure?

YES NO Do you have night sweats?

Three or more **YES answers to these questions means you should be further evaluated for Sleep Apnea. Five (5) or six (6) **YES** answers means there is a very good possibly you have Sleep Apnea**