Welcome to Oak Hills Dentistry! We are so happy to have you here!

Today's Date: _____

Patient Information

Patient Name: _____
Last Name First Name Middle

Preferred Name: _____ Family Status: ☐Single ☐Married ☐Child ☐Other

Mailing Address: _____
Street Apt/Unit# City State Zip

Patient Birthdate: _____ Social Security # (If patient is over 18yrs old) : _____ Gender: M ☐ F ☐ Other ☐

Email Address: _____

Primary Phone #: _____ Home ☐ Cell ☐ Work ☐ Secondary Phone #: _____ Home ☐ Cell ☐ Work ☐

How did you hear about our office? (If referred by another patient, please tell us their name so we can thank them): _____

Responsible Party/Guardian Information

*If this information is the same as above you may skip the next 4 lines and continue at the *Employer information section.

Name: _____ Birthdate: _____
Last Name First Name Middle

Social Security #: _____ Relationship to Patient: _____

Mailing Address: _____
Street Apt/Unit# City State Zip

Primary Phone #: _____Home ☐ Cell ☐ Work ☐ Secondary Phone #: _____Home ☐ Cell ☐ Work ☐

*Employer: _____ Occupation: _____ # Years Employed: _____

Spouse Name: _____ Birthdate: _____ SS #: _____
Last First Middle

Spouse Primary Phone #: _____ HM ☐ Cell ☐ WRK ☐ Spouse Secondary Phone #: _____ HM ☐ Cell ☐ WRK ☐

Spouse Employer: _____ Occupation: _____ # Years Employed: _____

Dental Insurance Information

Subscriber Name: _____ Subscriber ID or SS #: _____

Subscriber DOB: _____ Insur Co. Name: _____ Insur Phone #: _____ Group #: _____

Subscriber Address (if different from patient): _____ Subscriber Employer: _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Secondary Subscriber Name: _____ ID or SS #: _____ Subscriber DOB: _____

Subscriber Address (if different from patient):_____ Subscriber Employer: _____

2nd Insurance Co. Name: _____ 2nd Insurance Phone #: _____Group #: _____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Medical Health **DOB: _____**

What would you consider your general health to be? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Primary Care Physician Name: _____ Physician Phone #: _____

Are you taking any medication? Yes ☐ No ☐ If Yes, Please List Below:

Medication: _____ For what purpose? _____

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Medication: _____ For what purpose? _____

Do you have OR have you ever had the following medical conditions:

Abnormal Blood Pressure: High/Low	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐
Abnormal Bleeding	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐
AFib	Yes ☐ No ☐	Heart Surgery	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Hepatitis Type_____	Yes ☐ No ☐
Angina (Chest Pain)	Yes ☐ No ☐	HIV+/AIDS	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Kidney Disease/Problems	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Artificial Bones/Joints	Yes ☐ No ☐	Lung Disease/COPD	Yes ☐ No ☐
Asthma/Difficulty Breathing	Yes ☐ No ☐	Mental Disability	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Mental Illness	Yes ☐ No ☐
Cancer Type_____	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐
Chemotherapy or Radiation Treatment	Yes ☐ No ☐	Organ Transplant	Yes ☐ No ☐
Colitis/Ulcers	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Congenital Heart Defect	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐
Dementia/Alzheimer's Disease	Yes ☐ No ☐	Rheumatic Fever/Scarlet Fever	Yes ☐ No ☐
Diabetes Type I or II	I ☐ II ☐ No ☐	Steroid Therapy	Yes ☐ No ☐
Epilepsy/Seizures	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Frequent/Severe Headaches	Yes ☐ No ☐	Substance Abuse Problems	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Hay Fever/Sinus Trouble	Yes ☐ No ☐	Tuberculosis (TB)	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Tumors	Yes ☐ No ☐

Are you allergic to: Penicillin:☐ Codeine:☐ Sulfa Drugs:☐ Erythromycin:☐ Dental Anesthetics:☐ Iodine:☐ Metals/Nickel:☐
Aspirin:☐ Ibuprofen:☐ Latex/Plastics:☐ Barbiturates:☐ Any Other Medications/Materials? _____

Do you take antibiotics prior to dental treatment?	Yes ☐ No ☐	Are you taking any blood thinners?	Yes ☐ No ☐
Are you subject to prolonged bleeding?	Yes ☐ No ☐	Are you subject to fainting spells?	Yes ☐ No ☐
Do you have excessive urination and/or thirst?	Yes ☐ No ☐	Do you use tobacco products?	Yes ☐ No ☐

Have you ever had or are you currently getting IV Zoledronic Acid Treatments (such as Zometa or Reclast)? Yes ☐ No ☐

Please list any Major Surgeries: Year: _____ Type of Surgery: _____ Year: _____ Type of Surgery: _____

If you have any other medical problems not listed please explain: _____

Women: Are you or could you be pregnant? Yes ☐ No ☐ If yes, expected due date? _____ Are you nursing? Yes ☐ No ☐

Dental Health: Previous Dentist's Name _____ Previous Dentist's Phone #: _____

Reason for your visit today: _____ When was your last dental visit? _____

Have you ever experienced problems associated with previous dental treatment? Yes ☐ No ☐ Explain: _____

Are you experiencing any tooth or mouth pain? Yes ☐ No ☐ Explain: _____

Are your teeth sensitive to hot, cold, or anything else? Yes ☐ No ☐ Explain: _____

How often do you brush your teeth? _____ How often do you floss? _____

Type of bristles on your toothbrush? Soft ☐ Medium ☐ Hard ☐ Do you use an electric toothbrush and/or WaterPik? Yes ☐ No ☐

Do your gums bleed when brushing? Yes ☐ No ☐ Do your gums bleed when flossing? Yes ☐ No ☐

Do you use a Night Guard? Yes ☐ No ☐ Do you use a Sleep Apnea Device or Snore Guard? Yes ☐ No ☐

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐ If no, what would you change? _____

Would you like your teeth to be whiter? Yes ☐ No ☐

I affirm that the information I have provided on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the staff of Oak Hills Dentistry to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Name (Please Print)	Patient Signature	Today's Date

OAK HILLS DENTISTRY

Oak Hills Dentistry
Tyler Bradstreet, DMD
14740 NW Cornell Rd Ste 120
Portland, OR 97229
(503) 690-0400 • www.oakhillsdentist.com

Your appointment time is reserved exclusively for you. We require two (2) full business days' notice (not including weekends or holidays) for cancellations or reschedules. Missed or late-cancelled appointments without proper notice may be charged a fee of $25.00 per half hour of scheduled time. Repeated broken appointments may result in higher fees, restricted scheduling, or dismissal from the practice. Documented medical emergencies will not result in a fee.

Consent & Authorization

By signing this form, you authorize Oak Hills Dentistry to release treatment information to your insurance company as needed and to receive payment directly from them. This authorization remains valid until revoked in writing. You acknowledge responsibility for all charges and agree to the terms of this financial policy.

Patient Name (Print): _____

Patient Signature (Parent/Guardian if minor): _____ Date: _____

Staff Witness (optional): _____ Date: _____

OAK HILLS DENTISTRY

HIPAA Acknowledgement & Consent

The staff at Oak Hills Dentistry is committed to maintaining the confidentiality of your personal, financial and health information. We are required by applicable federal and state laws to maintain the privacy of your personal health information. We are also required to give you this notice. This notice took effect in April 2003 and will remain in effect until we replace it.

By signing this form, you 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 that you are aware of our needs to share information and received your rights notification explaining in detail our office policy and information sharing policy.

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

We reserve the right to change our privacy policies described in our office patient right privacy policy and information practices. If we do change our practices, we will make available a revised patient and information privacy update statement.

We request that you provide notification to us of any changes in your personal information we maintain for you in a timely manner.

You may obtain a copy of Notice of Privacy Practices by contacting us at 503-690-0400 or mailing us your request in writing to: Oak Hills Dentistry Attn: Dr. Bradstreet 14740 NW Cornell Rd Ste 120 Portland, OR 97229

By singing this form, you confirm you have read the above information and have received a copy of this office's Notice of Privacy Practices. Your signature also gives consent to Dr. Tyler Bradstreet, DMD & staff to use and disclose your protected health information to carry out treatment, payment activities and health care operations.

_____

Patient Name (Please Print)

_____ _____

Patient Signature (Parent or Guardian if Patient is a Minor) Date

_____

For Office Use Only

We attempted to obtain a written acknowledgement of Receipt of Notice of Privacy Policy and Information Practices, but it could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier kept us from obtaining acknowledgement
_____ An emergency situation kept us from obtaining acknowledgement
_____ Other_____

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Tyler Bradstreet, DMD
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Portland, OR 97229
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Financial & Broken Appointment Policy

Payment Responsibility

Payment is due in full at the time of service, including insurance deductibles, estimated out-of-pocket costs, and any laboratory fees incurred once treatment has been authorized. If you have dental insurance, we will help prepare and submit claims as a courtesy; however, insurance estimates are not guarantees of coverage, and you are financially responsible for all charges regardless of insurance payment. Non-covered services, including cosmetic or elective procedures, are the patient's responsibility. If you have secondary insurance, we will assist with claim submission, but all balances remain your responsibility.

Courtesy Adjustments & Discounts

Any courtesy adjustments, professional discounts, or special fee arrangements provided by Oak Hills Dentistry are discretionary. These adjustments are only available to patients in good standing with treatment, attendance, and financial obligations, and they may be revoked at any time at the discretion of the practice.

Deposits & Payment Arrangements

For major restorative treatments such as crowns, implants, or dentures, a deposit may be required before treatment begins. Any payment plan or special arrangement must be made prior to treatment and approved by the office manager. Laboratory fees are non-refundable once fabrication has begun, regardless of whether the treatment is completed.

Balances, Interest & Collections

Balances over 60 days from the date of service may be subject to interest at 5-10% per month or a $5.00 rebilling fee, whichever is greater. Accounts sent to collections will be assessed an additional $100 processing fee, and you will be responsible for reasonable attorney's fees and collection costs. Balances under $5.00 may be written off at the discretion of the practice.

Returned Payments

Returned checks will be charged a $30.00 fee per incident. After a returned check, all future payments must be made by cash, credit card, or certified funds.

Broken Appointment Policy

TMJ History & Questionnaire

Patient Name: _____

Have you ever been diagnosed with a problem involving either jaw joint?

☐ **No** ☐ **Yes** If yes, indicate location: ☐ **Right** ☐ **Left** ☐ **Both**

Do you notice clicking, popping, or grinding noises when opening or closing your mouth?

☐ **No** ☐ **Yes**

If yes: ☐ **Clicking** ☐ **Popping** ☐ **Grinding** **Which side?** ☐ **Right** ☐ **Left** ☐ **Both**

Does your jaw ever feel like it catches, locks, or gets stuck?

☐ **No** ☐ **Yes** If yes: ☐ **Open** ☐ **Closed** ☐ **Both**

Do you have frequent headaches?

☐ **No** ☐ **Yes** If yes, how often and when: _____

Do you clench or grind your teeth, or have you been told that you do?

☐ **No** ☐ **Yes**

Do you have a history of trauma to your chin or jaw?

☐ **No** ☐ **Yes**

Additional Comments:

_____

_____

OAK HILLS DENTISTRY

DR. TYLER BRADSTREET

14740 NW Cornell Rd. #120, Portland, OR 97229
503-690-0400

REQUEST FOR RELEASE OF RECORDS

I hereby request and give my permission to _____to release my dental records to:

TYLER BRADSTREET, DMD
14740 N.W. CORNELL RD., SUITE 120
PORTLAND, OR 97229
E-mail: info@oakhillsdentist.com

Printed Name: _____

Signature: _____ Date:_____