PETER T. RAVEN, DDS, LLC
STEVEN W. THURN, DMD

DATE_____

PATIENT INFORMATION

NAME_____ □ MALE □ FEMALE

ADDRESS_____
STREET CITY STATE ZIP

PHONE: HOME _____ WORK _____ CELL _____ EMAIL_____

PREFERRED METHOD TO CONTACT YOU: □ HOME □WORK □ CELL IF FULL TIME STUDENT, SCHOOL NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ □ MARRIED □ SINGLE □ WIDOWED □ DIVORCED □ OTHER

EMPLOYER NAME/PHONE_____ PERSON RESPONSIBLE FOR ACCOUNT:□ PATIENT□ FATHER□ MOTHER□ OTHER

INSURANCE INFORMATION

This information should be about the subscriber of the insurance.

PRIMARY DENTAL INSURANCE

_____
LAST FIRST M.I.

_____
INSURED'S ADDRESS PHONE

_____
INSURANCE CO. NAME/ ADDRESS CITY STATE ZIP

_____
INSURANCE CO. PHONE NUMBER GROUP NUMBER

_____
SSN/ ID NUMBER DOB EMPLOYER

RELATIONSHIP TO INSURED □ SELF □ SPOUSE □ CHILD □ OTHER

ADDITIONAL DENTAL INSURNCE

_____
LAST FIRST M.I.

_____
INSURED'S ADDRESS PHONE

_____
INSURANCE CO. NAME/ ADDRESS CITY STATE ZIP

_____
INSURANCE CO. PHONE NUMBER GROUP NUMBER

_____
SSN/ ID NUMBER DOB EMPLOYER

RELATIONSHIP TO INSURED □ SELF □ SPOUSE □ CHILD □ OTHER

EMERGENCY CONTACT

NAME_____

RELATIONSHIP_____

ADDRESS_____

HOME PHONE_____ CELL_____

ABOUT YOU

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?_____

DO WE TREAT ANY OTHER FAMILY MEMBERS?_____

NAMES:_____

IS THERE ANYTHING ABOUT YOUR SMILE THAT YOU ARE UNHAPPY WITH?_____

TERMS & CONDITIONS

- I hereby authorize Peter T. Raven, DDS, LLC and his staff to perform dental treatment on the above named patient and release any medical/dental information to the insurance company as required. I further authorize that insurance benefits be paid to Dr. Peter Raven.
- I understand that as a courtesy, my insurance will be billed. In the event the insurance company does not pay, I am solely responsible for the bill. If my account is sent to a collection agency, I am responsible for any and all cost associated with this.
- We accept cash, check, debit and credit cards (Visa, MasterCard, Discover and CareCredit). A service charge of 1.5% will be applied to balances over 90 days.
- I have read and understand that payment is due at the time services are rendered, unless prior arrangements have been made.

_____
Signature Date

Peter T. Raven, DDS, LLC
Steven W. Thurn, DMD
222 6th Street Springfield OR, 97477
Telephone (541) 988-5555 www.RavenDental.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ~ Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- ~ Obtain payment from third-party payers.
- ~ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time during regular business hours at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient: self_____ parent_____ guardian_____ other_____

Signature_____Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date_____ Initials_____ Reason_____

_____

Peter T. Raven, DDS, LLC Steven W. Thurn, DMD

222 6th Street Springfield OR, 97477
Telephone (541) 988-5555 www.RavenDental.com

Patient's Name: _____ Date of Birth:_____
Last First Initial

DENTAL HISTORY

Reason for Today's visit: _____
Date of last dental care: _____ Date of last dental X-rays_____

Circle Yes or No if you have had any of the following:

Yes	No	Bad Breath	Yes	No	Grinding teeth	Yes	No	Sensitivity to hot
Yes	No	Bleeding gums	Yes	No	Loose teeth	Yes	No	Sensitivity to sweets
Yes	No	Clicking or popping jaw	Yes	No	Periodontal treatment	Yes	No	Sensitivity when biting
Yes	No	Food collection between Teeth	Yes	No	Sensitivity to cold	Yes	No	Sores/growths in your mouth

Is there anything about your smile you would like to change?

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____
Have you ever had any serious illness or operation? _____If yes, please describe: _____
_____

Circle Yes or No if you have had any of the following:

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No
Do you use alcohol? Yes No Tobacco? Yes No Other Drugs? Yes No

Yes	No	Anemia	Yes	No	Diabetes Type I,II	Yes	No	Hemophilia	Yes	No	Radiation Treatment
Yes	No	Arthritis	Yes	No	Drug Addiction	Yes	No	Hepatitis A,B,C			
Yes	No	Artificial Heart Valves	Yes	No	Eating Disorder	Yes	No	High Blood Pressure	Yes	No	Respiratory Disease
			Yes	No	Endocarditis						
Yes	No	Artificial Joints	Yes	No	Epilepsy/Seizures	Yes	No	HIV Positive	Yes	No	Stroke
Yes	No	Asthma	Yes	No	Fainting	Yes	No	Kidney Disease	Yes	No	Thyroid Problems
Yes	No	Blood Disease	Yes	No	Glaucoma	Yes	No	Liver Disease			
Yes	No	Cancer	Yes	No	Heart Murmur	Yes	No	Pacemaker	Yes	No	Tuberculosis
Yes	No	Chemotherapy	Yes	No	Heart Problems	Yes	No	Psychiatric Care	Yes	No	Ulcer

Other Please Describe:

MEDICATION (PERSCRIPTION AND NON-PERSCRIPTION)

List all medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ None

ALLERGIES / PHARMACY

☐ Aspirin
☐ Codeine
☐ Latex
☐ Penicillin
☐ Sulfa
☐ Other _____

☐ None

Pharmacy Name: _____

Phone: _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: Date: