Welcome

THERESA K. TUCKER, DDS
DANIEL P. GAILIS, DMD
General Dentistry
2586 Clover St. • Klamath Falls, OR 97601

Patient Information

Name _____

Address _____

City _____ Zip _____

Phone: hm _____ cell _____

Sex: ☐ M ☐ F Age _____ Bday _____

Employer _____

Employer phone _____

Referred by _____

Emergency Contact Information

Spouse or parent name _____

Phone _____

Spouse's Bday _____

Spouse's employer _____

Dental Information

Any dental concerns today? _____

Date of last dental exam _____

Date of last X-rays _____

Health History

Physician's Name _____ Date of last visit _____

Circle all that apply:

ANY ADDICTIONS	CHEMO/RADIATION	HEART ATTACK	OSTEOPOROSIS MEDS
ASTHMA	CONGESTIVE HEART FAILURE	HEPATITIS _____(TYPE)	PSYCHIATRIC THERAPY
ARTIFICIAL HEART VALVE	COUGH - PERSISTENT, BLOODY	HERPES	STROKE
ARTIFICIAL JOINTS	DIABETES	HIGH BLOOD PRESSURE	THYROID PROBEMS
BLEEDING PROBLEMS	ENDOCARDITIS	HIV/AIDS	TMJ DISORDER
BREATHING PROBLEMS (COPD)	EPILEPSY	JAUNDICE	TOBACCO USE
CANCER	GLAUCOMA	KIDNEY DISEASE	TUBERCULOSIS

Any other disease or illness not listed above: _____

Have you been hospitalized in the last three years? Why? _____

Women: Are you pregnant? ☐ Yes ☐ No Due date _____ Taking birth control pills? ☐ Yes ☐ No

Medications you are currently taking: _____

Allergies

Have you ever had an adverse reaction to:

☐ Local Anesthetics ☐ Antibiotics _____ ☐ Latex ☐ Codeine ☐ Aspirin/Advil ☐ Other _____

Signature of patient or parent _____ Date _____

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I am covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my/minor child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

As a courtesy, we will bill your insurance company for you; however, it is your responsibility to know what your insurance will cover and how benefits will be paid.

____ ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Initial

FINANCIAL AGREEMENT

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employees such assistance as he deems fit. I agree to pay for all services rendered by this office. I also authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered to me or my dependent.

I understand that all accounts are due and payable within 15 days of billing. A LATE PAYMENT CHARGE of 1-1/2% per month of the unpaid will be charged on past due accounts. This is an ANNUAL PERCENTAGE RATE OF 18% PER ANNUM. Minimum LATE PAYMENT CHARGE will be $2.00 per month.

I agree to pay attorney's fees, costs and disbursements incurred for collection of my past due accounts including costs of trial and appeals. Where appropriate and necessary credit bureau reports will be obtained.

I understand that I will be billed $50.00 for any missed or cancelled appointment with less than 24 hour cancellation notice.

SIGNATURE OF RESPONSIBLE PARTY	RELATIONSHIP	DATE

TREATMENT WILL NOT BE RENDERED WITHOUT A SIGNATURE.