Helen K. Lester D.D.S., FAGD, AFAAID, PC
Comprehensive Dentistry
330 S. Garden Way, Ste. 190
Eugene, OR 97401
(541) 686-2320

PATIENT REGISTRATION

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____

Responsible Party (If patient is a minor, or if someone other than the patient)

First Name: _____ Last Name: _____ MI: _____
Address: _____ Address 2: _____ Birth Date: _____
City, State, Zip: _____ Home Phone: _____ Cell: _____
Work Phone: _____ Ext: _____ Drivers Lic: _____ Soc. Sec: _____
☐ Responsible Party ☐ Primary Ins. Holder ☐ Secondary Ins. Holder

Patient Information

First Name: _____ Last Name: _____ MI: _____
Address: _____ Address 2: _____ Birth Date: _____
City, State, Zip: _____ Home Phone: _____ Cell: _____
Work Phone: _____ Ext: _____ Drivers Lic: _____ Soc. Sec: _____
Employment/Student Status: _____ Employer/School: _____
☐ Responsible Party ☐ Primary Ins. Holder ☐ Secondary Ins. Holder

Primary Dental Insurance Information	**Secondary Dental Insurance Information**
Ins. Company: _____	Ins. Company: _____
Subscriber ID Number: _____	Subscriber ID Number: _____
Group Number: _____	Group Number: _____
Primary Insured's Name: _____	Primary Insured's Name: _____
Primary Insured's DOB: _____	Primary Insured's DOB: _____
Ins. Claims Mailing Address: _____	Ins. Claims Mailing Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone No.: _____	Phone No.: _____

_____ _____
Signature Date

Helen K. Lester DDS, FAGD, AFAAID, PC
Comprehensive Dentistry
MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

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: _____
**Do you take bone sparing drugs for osteoporosis? __Yes __No If yes: _____
Are you on a special diet? __Yes __No If yes: _____
Do you use tobacco? __Yes __No If yes: _____
Do you use controlled substances? __Yes __No If yes: _____
Are you taking any medications, pills or drugs? __Yes __No Please List: _____

Current Physician's Name: _____

Women: Are you...
Pregnant/Trying to get pregnant? __Y __N *Taking oral contraceptives?* __Y __N *Nursing?* __Y __N
****ANTIBIOTICS MAY REDUCE THE EFFECTIVENESS OF ORAL CONTRACEPTIVES****

Are you allergic to any of the following?
Aspirin__ Penicillin__ Codeine__ Acrylic__ Metal__ Latex__ Local Anesthetics__ Sulfa__
Other__ If yes, please explain: _____

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

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

Have you ever had a serious illness not listed above? __Yes __No If yes, please explain:

_____

_____

_____

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) heath. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient or guardian: _____ **Date:** _____

Helen K. Lester D.D.S., FAGD, AFAAID, PC
Comprehensive Dentistry
330 S. Garden Way. Ste. 190
Eugene, OR 97401
(541) 686-2320

TMJ Self Exam Checklist

___Have you ever had braces?
___Do you have a grating, clicking, cracking, or popping in either or both jaw joints when you open your mouth or chew?
___Do you have sensations of stuffiness, pressure or blockages in your ears?
___Do you ever have a ringing, roaring, hissing or buzzing sound in your ears?
___Is your jaw painful or locked when you get up in the morning?
___Do you snore?
___Do you use a CPAP machine?
___Are you ever nauseous for no apparent reason?
___Do you fatigue easily or consider yourself chronically fatigued?
___Are there imprints of your teeth on the side of your tongue?
___Does your tongue go between your front teeth when you swallow?
___Do your fingers sometimes go numb for no reason?
___Do you have pain or soreness in any of the following areas (please circle): jaw joints, upper jaw or teeth, lower jaw or teeth, side of neck, back of head, forehead, behind eyes, temples, tongue, chewing muscles.
___Do you have difficulty when swallowing of chewing your food?
___Do you have any missing back teeth?
___Have you had extensive dental crowns or bridgework?
___Do you clench or grind your teeth during the day or night?
___Do you ever awaken with a headache?
___Have you ever had a whiplash injury or any other injury to your jaw?
___Have you ever worn a cervical collar or had neck traction?
___Have you ever experienced a blow to the chin, face, or head?
___Have you reached the point where prescription drugs no longer relieve your symptoms?
___Do you chew gum?
___Does it hurt when you press on your jaw joints or the side of your face?
___Is it painful to stick your little finger into your ears with your mouth open wide and then close your mouth while pressing forward with those fingers? (It sounds strange but try it).
___Does your jaw deviate to the left or right when you open wide?
___Is it uncomfortable to insert your first 3 fingers vertically into your mouth when it is opened wide?

Patient Signature Date

Helen K. Lester D.D.S., FAGD, AFAAID, PC
Comprehensive Dentistry
330 S. Garden Way, Ste. 190
Eugene, OR 97401
(541) 686-2320

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this authorization, you agree to the release of your Protected Health Information[1] as described in this authorization. This authorization is intended to comply with the requirements of the HIPAA[2] Privacy Rule[3]. If you have questions about this authorization please contact the office. If you agree with this authorization, please complete the form below, sign, and date.

Your contact information:

Patient Name: _____

Patient Mailing Address:

_____

_____

_____

Patient Email Address:

_____

Patient Phone Numbers (Home, Cell & Work):

_____

I authorize Helen K. Lester DDS, FAGD, PC to release my Protected Information to the following person(s):

_____ **Relationship:** _____

Signature: _____ **Date:** _____

[1]Protected Health Information is (i) about your physical or mental health or condition, heath care, or the healthcare: (ii) that identifies you directly or indirectly (i.e., there is a reasonable basis to believe that the information could be used to identify you): and (iii) that is maintained or transmitted by the Health Plan. [2]HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. [3]The Privacy Rule refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

Helen K. Lester D.D.S., FAGD, AFAAID, PC
Comprehensive Dentistry
330 S. Garden Way, Ste. 190
Eugene, OR 97401
(541) 686-2320

Cancellation Policy

Although we know that unforeseen events and circumstances arise from time to time, it is important for patients to honor their appointments. We try out best to respect each patients time and we ask the same of you.

We go to great lengths to provide courtesy reminders by phone, email, text and postcards, for appointments, but once you have scheduled with us, the responsibility is ultimately still yours to keep the appointment or contact our office and cancel by speaking to one of our staff members 48 hours prior to your appointment.

Our cancellation policy is that, upon your first cancellation less than 48 hours prior to your scheduled appointment, we will not charge you a cancellation fee as long as you reschedule your appointment promptly. After the first time, a $75 cancellation fee will be applied to your account for any other cancellations less than 48 hours prior to your scheduled appointment.

As always, if you cancel 48 hours in advanced by talking directly to our office staff, rather than leaving a voicemail, no fee will be charged.

Patient Name (Print) Date

Signature of Patient or Guardian Date

Helen K. Lester D.D.S., FAGD, AFAAID, PC
Comprehensive Dentistry
330 S. Garden Way, Ste. 190
Eugene, OR 97401
(541) 686-2320

GENERAL CONSENT TO DIAGNOSE AND TREAT

The undersigned hereby grants permission to Helen K. Lester D.D.S., FAGD to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Helen K. Lester D.D.S., FAGD deems necessary. I understand that the use of local anesthetic agents embodies certain risk and consent to their use as deemed appropriate by Helen K. Lester D.D.S., FAGD. To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status. I authorize Helen K. Lester D.D.S., FAGD to take and use: radiographs, study models, photographs, or any other diagnostic aids deemed appropriate for the use of promotional or educational materials. These materials may include printed or electronic publications, websites or other electronic communications. I authorize the use of these images without compensation to me or others who may or may not be in the images. All negatives, prints, and digital reproductions shall be the property of Helen K. Lester D.D.S., FAGD.

We do not place silver amalgam in our office

FINANCIAL CONSENT

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. As a service to our patients we bill insurance as a courtesy, but please remember you are fully responsible for all fees charged regardless of your insurance coverage. We request your estimated patient portion be paid at the time of service.

Most insurance companies will respond within four to six weeks. Any remaining balance after your insurance has paid is your responsibility; we will gladly send you a monthly statement. Your prompt remittance is appreciated. We can make arrangements for a monthly payment plan, but that must be implemented prior to the completed procedure. For your convenience, we accept Checks, Cash, Visa, MasterCard, Discover Card, Compassionate Finance, and Care Credit. We deliver the finest care at the most reasonable cost to our patients, therefore payment is due at the time service unless other arrangements have been made in advance.

I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Helen K. Lester D.D.S., FAGD and staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Patient Name (Print) **Date**

Signature of Patient or Guardian **Date**