MUELLER Implants & Periodontics

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Board Certified in Periodontology and Dental Implant Surgery

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www.muellerimplantsandperio.com
(541) 757 - 8330

PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Occupation: _____ Employer: _____ Phone: _____
Referred By: _____ General Dentist: _____
Emergency Contact: _____ Phone: _____ Relationship to patient: _____
Spouse/Partner: _____ Date of Birth: _____ Phone: _____
Occupation: _____ Employer: _____

INSURANCE INFORMATION

Primary Dental Insurance: _____	Secondary Dental Insurance: _____
Insurance Co. Phone: _____	Insurance Co. Phone: _____
Subscriber/Employee: _____	Subscriber/Employee: _____
Subscriber ID# _____ DOB: _____	Subscriber ID# _____ DOB: _____
Employer: _____	Employer: _____
Group #: _____	Group #: _____

AUTHORIZATION

I authorize payment of insurance benefits to be paid to the provider.

I understand that there is a fee associated with my exam, and that I am responsible for paying it.

I understand I am responsible for all costs of treatment and acknowledge that finance charges will accrue on any unpaid balance after 90 days.

I authorize the provider to administer medications and/or perform diagnostic and therapeutic procedures as necessary.

If you unable to keep your appointment, please notify us at least 48 hours in advance. Appointments cancelled or changed with less than 48-hour notice will be charged a $50.00 cancellation fee.

The information on this form is correct to the best of my knowledge.

Signature of Responsible Party: _____ Date: _____

Relationship to Patient: ☐ Self OR ☐ Legal Guardian

NEXT PAGE

Patient Name: _____ Date: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone: _____

Other Physician: _____ Specialty: _____ Phone: _____

Other Physician: _____ Specialty: _____ Phone: _____

Are you currently under a doctor's care? _____ If yes, please explain: _____

Have you been hospitalized or had surgery in the last 5 years? _____ If yes, please explain: _____

Women: Are you pregnant? _____Due Date: _____Are you Nursing: _____

Do you smoke/Chew Tobacco?	☐ Yes	☐ No	Amount/Day: _____ How long? _____
Do you use alcohol?	☐ Yes	☐ No	Drinks/Week: _____

Have you ever had an unfavorable reaction following dental treatment? _____

If yes, please explain: _____

Has a physician recommended antibiotic premedication for dental treatments? _____

Why was premedication recommended? ☐ Joint replacement ☐ Medical Condition ☐ Heart Condition

What medication was recommended? _____

Are you sensitive or allergic to:		
Antibiotics: ☐ Amoxicillin ☐ Erythromycin ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline	Other Allergies: ☐ Codeine ☐ Metals ☐ Latex ☐ Sedatives ☐ Bee Pollen	Dental Anesthetics: ☐ Topical (Numbing) ☐ Local Anesthetic (Numbing Injection) OTHER: _____

Have you taken in the past 12 years, or are you currently taking, any bisphosphonate medications? _____

Please indicate medication: ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Other _____

How was medication administered? ☐ Intravenous OR ☐ Orally

How long did you take medication? _____

Are you taking any prescription/recreational medications, supplements, or vitamins at this time? _____

Are you currently on a Pain Contract or regularly taking any pain medications? _____

Current medications you are taking:

NEXT PAGE

Patient Name: _____ Date: _____

MEDICAL/DENTAL CONDITIONS

Do you have or have you experienced any of the following? Please check all that apply.

☐ AIDS/HIV	☐ Epilepsy or Seizures	☐ Nervousness/Anxiety/Depression
☐ Abnormal Bleeding	☐ Excessive Thirst	☐ Neurological Disorders
☐ Alcohol Addiction	☐ Fainting or Dizzy Spells	☐ Organ Transplant
☐ Alzheimer's or Dementia	☐ Fibromyalgia	☐ Osteoporosis
☐ Anemia	☐ Glaucoma	☐ Pacemaker
☐Arthritis/Gout	☐ Hay Fever	Date Placed: _____
☐ Artificial Joints/Pins	☐ Headaches	Type: _____
Joint Location: _____	☐ Hearing Problems	☐ Parkinson's
Date Placed: _____	☐ Heart Attack	☐ Persistent Cough
☐ Artificial Heart Valve	Date: _____	☐ Radiation Therapy
☐ Asthma	☐ Heart Disease	☐ Recent Weight Loss/Gain
☐ Bladder Trouble	☐ Heart Murmur	☐ Rheumatic Fever
☐ Blood Disease	☐ Heart Surgery	☐ Rheumatism
☐ Blood Thinners/Anticoagulants	Type of surgery: _____	☐ Scarlet Fever
☐ Blood Transfusion	☐ Heart Trouble	☐ Seizure Disorder
☐ Cancer/Tumors	☐ Hemophilia	☐ Sexually Transmitted Disease
List Type: _____	☐ Hepatitis A	Type: _____
☐ Chemotherapy	☐ Hepatitis B	☐ Shingles
☐ Chest Pains	☐ Hepatitis C	☐ Shortness of Breath
☐ Chicken Pox	☐ Herpes	☐ Sickle Cell Disease
☐ Cold Sores	☐ High Blood Pressure	☐ Sinus Trouble
☐ Colitis	☐ Kidney Disease	☐ Sleeping Disorder/CPAP
☐ Congenital Heart Defect	☐ Limited Mobility	☐ Stroke/CVA
☐ Diabetes	Requiring assistance?	☐ Steroid Therapy
Type: ☐ I OR ☐ II	☐ Liver Disease	☐ Swelling of feet/ankles
Recent HbA1c Value: _____	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Hypoglycemic	☐ Lung Disease	☐ Tonsilitis
☐ Difficulty Breathing	☐ Lupus	☐ Tuberculosis
☐ Drug Addiction	☐ Mental or Psychiatric Care	☐ Ulcers/Acid Reflux
☐ Emphysema/COPD	☐ Mitral Valve Prolapse	☐ Other:_____

Please list any serious medical conditions not indicated above that you have experienced in the last 5 years:

_____

_____

_____

_____

Pharmacy: _____ City: _____

Signature: _____ Date: _____

BISPHOSPHONATE NOTICE

Important notice to patients taking medications for the treatment of:

- Osteoporosis
- Osteopenia
- Bone Cancer
- Metastatic Breast Cancer
- Postmenopausal bone loss

Patients Printed Name: _____ Date of Birth: _____

The class of medications used to treat these conditions is known as Bisphosphonates. These medications have been linked to a serious side effect called *osteonecrosis of the jaw.* This condition may be triggered by certain dental procedures, poor oral health, or ill-fitting denture appliances. If you have ever taken one of these medications, maintaining your oral health is even more important.

The incidence of this conditions (*osteonecrosis)* is far greater if the medications have been administered by intravenous means. However, it has been reported in patients taking oral forms of these drugs.

I.V Bisphosphonates	Oral Bisphosphonates
Aredia (Pamidronate)	Fosamax (Alendronate)
Zometa (Zoledronate)	Boniva (Ibandronate)
Boniva (Ibandronate)	Actonel (Risedronate)
	Benefos (Clodronate)
	Ostac (Clodronate)
	Skelid (Tiludronate)
*Any other Bisphosphonates	Didvonel (Etidronate)

The complications associated with these medications may be years to lifelong even after you stop taking them.

I certify that I have read and fully understand the above notice.

Patient or guardian signature: _____ Date: _____

_____I have not taken any of these medications.
(Initial)

-OR-

_____ I have taken, or am currently taking, or have been administered one or more of these medications.
(Initial)

CONFIDENTIAL

AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize: **MUELLER IMPLANTS AND PERIODONTICS**
(Name of physician/physician group)

To use and disclose a copy of the specific health and medical information described below regarding:

_____
(Name of patient/SELF)

consisting of: **ALL ACCOUNT OR TREATMENT INFORMATION**
(Describe information to be used/disclosed)

to: _____
(First and last name of persons over 18) *(relation to patient)*

for the purpose of: **ANY OCCASION**
(Describe each purpose of disclosure or indicate that disclosure is at the request of the individual)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION: You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to HIPPA Rep with Mueller Implants and Periodontics at 2601 NW Rolling Green Drive Corvallis, Oregon 97330 and state that you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. Unless revoked, this authorization expires _____.
(*Insert either applicable date or event)*

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority: _____ Date: _____