Florence Dental Clinic
2750 Kingwood St
Florence, OR 97439
Ph- (541)997-3535
Fax- (541)997-3186
Email- info@holmeslintondental.com

Dr. Brian Holmes, DMD, FAGD
Dr. Justin Linton, DDS
Dr. Travis Alcorn, DDS

Hours:
Monday-Thursday
8:00-5:00
Friday
8:00-3:00
Closed the first Friday of every month. Paventy & Brown Orthodontics see local patients at our location that day.

Services:
General Dentistry
Cosmetic Dentistry
Implant Restoration
Crowns & Bridges
Root Canals
Hygiene Treatment
Periodontal Treatment
Soft Tissue Laser Therapy
Emergency Treatment
All Ages

Welcome to our practice!

On behalf of our staff, we welcome you to our office. We are pleased that you have selected us to care for your dental needs and we look forward to your initial visit.

We want you to know that we are committed to provide you with the highest quality of oral health care in the most gentle, efficient, and enthusiastic manner possible.

You will find this letter attached to our packet of new patient paperwork. The information you provide is essential for us to give you the best quality care. Each page is important. If you have any questions regarding this paperwork please don't hesitate to give us a call. Also, please include a list of current medication you are taking.

We are providing this packet ahead of time to give you a chance to complete it prior to your appointment. We recommend returning this packet at least 7 days before your appointment to give us time to upload all of your information and receive your previous dental records. Please arrive 15 minutes early if you do not get a chance to complete it ahead of time as it will delay your appointment.

We respect the value of your time, and except for emergency situations, you can expect us to be on time for you. We will appreciate the same courtesy.

We look forward to providing for your oral health care needs!

Thank you,

Florence Dental Clinic

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____ Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber Birthday:_____

Subscriber Name_____ Subscriber ID # _____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber Birthday:_____

Subscriber Name_____ Subscriber ID # _____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

Comments:

Medical History

Last Name: First Name: Birthdate:

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List any medications that you are currently taking:

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Ibuprofen
☐	☐	Anesthetic	☐	☐	Sulfa
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Epinephrine
☐	☐	Other Allergies: _____			

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Dental Anxiety
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Heart Valve Replacement	☐	☐	Rheumatic Fever
☐	☐	Hepatitis	☐	☐	HIV / AIDS
☐	☐	Thyroid Disease	☐	☐	Excessive Thirst
☐	☐	Snoring / Sleep Apnea	☐	☐	Joint Replacement

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients only:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date: _____

Patient Signature

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Standard Consent for Treatment and Payment

We are complimented that you have selected us to provide dental care for you.

The undersigned hereby authorizes the providers of this office to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the provider to make a thorough diagnosis of the patient's dental needs.

I authorize the dental provider to perform all recommended treatment mutually agreed upon by me and to use the appropriate medications and therapy indicated for such treatment.

I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the provider choose and employ such assistance as deemed fit to provide recommended treatment.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a one and one half percent monthly finance charge (18% APR) will be added to my account after 90 days, and I agree to pay it. I understand that if my balance becomes delinquent and no arrangements can be made, my account will be forwarded to a collection agency.

Patient Name:_____ DOB:_____

Patient/Guardian Signature:_____ Date:_____

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Acknowledgment of Notice of Privacy Practices

I understand that Florence Dental Clinic, P.C. (referred to as "This Practice") will use and disclose health information about me.

I understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about, and plan for, my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative, and business functions that support my provider's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices and that This Practice is not required by law to agree to such requests. I understand that if someone other than I is the insured, I authorize communication between that person and This Practice. If I am under the age of 18 and my parents are providing my health insurance, I authorize communications between them and This Practice.

I hereby authorize This Practice to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying This Practice in writing. I understand that once this information is disclosed, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____ DOB:_____

Patient/Guardian Signature:_____ Date:_____

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Authorization to Disclose Health Information to Family/Friends

I, _____, give permission to Florence Dental Clinic to disclose and release my protected health information to:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

I understand this health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

I understand that I may revoke this authorization at any time by notifying Florence Dental Clinic in writing.

Patient Signature:_____ Date:_____

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Authorization to Release Dental Records

We have a mutual patient and would appreciate all BW and PA x-rays from the last 2 years, FMX and Pano x-rays from the last 5 years, perio charts, current probings, and SRP history if applicable. Please send records to the email provided above.

Date:_____

Requesting Records From:_____

Phone:_____

Fax:_____

Email:_____

Patient Name:_____ DOB:_____

Patient/Guardian Signature:_____