

**Brock A. Van Gordon, DMD, P.C.**  
Family & Cosmetic Dentistry  
30045 SW Parkway Avenue  
Wilsonville, OR 97070

**Patient Information**

(This information is necessary for our files and will be considered CONFIDENTIAL)

Date _____			
Patient's name _____		Age _____	Birthdate _____
Last	First	M.I.	
Residence Address _____			
Street	City	Zip	
Phone(    ) _____	Cell Phone:(    ) _____	SS# _____	
Employer _____	Bus. Phone(    ) _____	Occupation _____	
Please provide your e-mail address if you would prefer to receive appointment reminders via e-mail.			
E-mail address _____			

Name of Physician _____	Office Phone(    ) _____
Former Dentist _____	Office Phone(    ) _____
Is this visit for Emergency Dental care? ___ Yes ___ No. If yes, explain _____	
_____	
How did you hear about us?	
___ Friend/Relative If so, whom can we send a gift to? _____	
___ Yellow ___ Dex Phone Book ___ Verizon Phone Book	
___ Website ___ Google ___ Yahoo	
___ Other: _____	

**Financial Information**

Person responsible for this account _____	Relationship _____		
Address _____	Phone(    ) _____		
Street	City	Zip	
<b>Primary Insurance</b>			
Insured's name _____	Company _____	Address _____	Telephone _____
SS# _____	Birthdate _____		
Employer _____	Group No. _____	Union/Local No. _____	
Relationship to patient _____			
<b>Secondary Insurance</b>			
Insured's name _____	Company _____	Address _____	Telephone _____
SS# _____	Birthdate _____		
Employer _____	Group No. _____	Union/Local No. _____	
Relationship to patient _____			

Signature _____	Date _____
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**Patient Medical History Information**

Patient's Name (Please Print) \_\_\_\_\_  
 Patient's Medical Doctor \_\_\_\_\_ City \_\_\_\_\_

Please answer all of the following questions below.

1. Are you currently under any medical treatment? Yes\_\_\_ No\_\_\_  
 If yes, explain \_\_\_\_\_
2. Are you taking any medications, injections or drugs at present time?  
 Yes\_\_\_ No\_\_\_ If yes, please list \_\_\_\_\_
3. Are you allergic to any medication or drugs including penicillin, codeine, aspirin, local anesthetic, latex, etc.? Yes\_\_\_ No\_\_\_  
 If yes, please list \_\_\_\_\_
4. Have you had any serious illness or operations in the past 5 years?  
 Yes\_\_\_ No\_\_\_ If yes, please list \_\_\_\_\_
5. Do you have any bleeding tendencies? Yes\_\_\_ No\_\_\_
6. Do you smoke cigarettes, cigars or use any tobacco products? Yes\_\_\_ No\_\_\_
7. Please answer the following by marking yes or no.

Yes	No		Yes	No	
_____	_____	AIDS/ HIV	_____	_____	Blood Transfusion
_____	_____	Diabetes	_____	_____	Chemotherapy
_____	_____	Artificial Joints	_____	_____	Drug Addiction
_____	_____	Asthma	_____	_____	Glaucoma
_____	_____	Chest Pains	_____	_____	Heart Murmur
_____	_____	Epilepsy	_____	_____	Hepatitis A B C
_____	_____	Heart Attack	_____	_____	Kidney Disease
_____	_____	Heart Trouble	_____	_____	Medical Treatment
_____	_____	High Blood Pressure	_____	_____	Rheumatic Fever
_____	_____	Liver Disease	_____	_____	Shortness of Breath
_____	_____	Psychiatric Treatment	_____	_____	Thyroid Disease
_____	_____	Sinus Trouble	_____	_____	Ulcer
_____	_____	Stroke	_____	_____	Tuberculosis
Other _____					

8. **For Women Only** are you pregnant? Yes\_\_\_ No\_\_\_ If yes, due date? \_\_\_\_\_  
 Are you nursing? Yes\_\_\_ No\_\_\_

I certify that the above is true and complete to the best of my knowledge. This form is completed by \_\_\_\_\_ Today's date \_\_\_\_\_  
Signature  
 If not patient, title of relationship \_\_\_\_\_

**Brock A. Van Gordon, D.M.D., P.C.**  
Family & Cosmetic Dentistry

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Wilsonville, OR 97070  
(503)682-2455

### **Insurance General Information**

To avoid misunderstandings regarding dental insurance, we would like our patients to know that all professional services rendered in this office are charged directly to the patient, who is ultimately responsible for payment of any and all fees. If your dental insurance company fails to pay their portion or fails to pay the claim within 60 days, you are responsible for payment of balance due in full for any service rendered.

Your insurance contract is a financial agreement between you and your employer, not our office. Although we strive to collect accurate information and give correct estimates, it is ultimately your responsibility to know your dental benefits.

Our office provides a variety of flexible payment alternatives for the patient portion of the balance due, which make it affordable to receive dental care. Unless alternative financial arrangements are made in advance, payment is due when services are rendered.  
Initial \_\_\_\_\_

### **How We Process Dental Insurance Claims**

1. When the service is rendered, the **estimated** patient co-payment is collected.
2. The claim form is electronically sent to the insurance company, along with any x-rays, intra-oral camera photographs or other necessary supplemental documentation.
3. We expect the insurance co-payment portion to be paid to our office within 30 -60 days.
4. If the insurance co-payment portion paid to us falls short of our original estimate, a bill for the balance due is created and mailed to the patient.
5. If the insurance co-payment portion is not paid within 60 days, a bill for the total balance due is mailed to the patient.

### **Authorization to perform dental treatment**

I hereby authorize Dr. Brock A. Van Gordon to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to prescribe any and all forms of medication and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. I understand that my responsibility of payment for dental services provided in this office for me or my dependents is mine, due payable at the time services are rendered.

Signature of patient or responsible party \_\_\_\_\_ Date \_\_\_\_\_

**Brock A. Van Gordon, DMD, PC**  
**30045 SW Parkway Avenue**  
**PO Box 3680**  
**Wilsonville, OR 97070**  
**(503)682-2455**

Dr. VanGordon and his team are committed to providing you with friendly and caring service. We will do our best to make your visit with us as comfortable as possible. Our team undergoes continuous training to bring dentistry's latest improvements into our office to provide the best services available to our patients. We look forward to establishing a long-term relationship with you as your dental care provider.

**Billing of Services**

As a courtesy, we will submit bills directly to your insurance company with our assignment of benefits so that payment can be made on your behalf. We will also be happy to bill more than one insurance company for you. Treatment estimates are not a guarantee of payment by your insurance company. We are not responsible for incorrect information supplied to us by your insurance carrier. It is your responsibility to confirm your benefits with your carrier. We do our best to give an accurate estimate and encourage you to familiarize yourself with your insurance plan and even contact them if necessary. Upon your request we are happy to supply you with a benefits page to assist you in verifying coverage and benefits.

Initial\_\_\_\_\_

Your cooperation in giving complete information to the admitting team members at each of your visits will help you get your insurance claim paid in a timely manner.

Initial\_\_\_\_\_

**Payment of Services**

Although we will bill your insurance and make all reasonable efforts to obtain payment from them, we will look to you for payment in full if there is a delay in payment of your claim or if your claim is denied. If your insurance has not paid after 60 days, you will be responsible for the balance. You are ultimately responsible for payment of your dental bills regardless of the type of insurance coverage.

Initial\_\_\_\_\_

**Payment Options**

We accept major credit cards as a convenience to you. Accounts that reach 30 days past due will be billed a finance charge of 18% based on the average daily balance. For patients wishing to make monthly payments, a billing service is available which offers a monthly payment plan.

**Appointment Policy**

We will gladly change appointment times to accommodate your schedule. However, we will need adequate notice prior to your appointment since we have reserved this appointment time only for you. A 24-hour notice is required for standard appointments. A 48-hour notice is required for appointments that exceed one hour. If insufficient notice is given, a fee of \$40.00 may be applied for each 30 minutes of appointment time missed.

Initial\_\_\_\_\_

I have read the above conditions of treatment and agree to their content.

Signature\_\_\_\_\_Date\_\_\_\_\_

### New Client Survey

Name \_\_\_\_\_ Date \_\_\_\_\_

**Please complete the following questions**

- |   | Yes   | No    |
|---|-------|-------|
| 1. I would like a complete & thorough dental examination  | _____ | _____ |
| 2. I would like to be informed of all the conditions in my mouth                                  | _____ | _____ |
| 3. I am interested in finding out about the most permanent and cost effective treatment available | _____ | _____ |
| 4. I am happy with the shape and color of my teeth  | _____ | _____ |

**On a scale of 1 to 10 (with 10 being the highest quality rating) how would you rate the following:**

How would you rate your overall oral health condition at present \_\_\_\_\_  
Where would you like your overall oral health condition to be \_\_\_\_\_

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- a. What are your primary concerns today?
  
- b. When was the last time you visited the dentist and for what reason?
  
- c. Have you ever had any of the following diagnostic evaluations:

An intra-oral camera exam	Y N	A panoramic x-ray	Y N
Digital x-rays	Y N	Laser cavity detection	Y N
A bite analysis	Y N	Oral Cancer Screening	Y N
Thorough periodontal screening	Y N	Caries risk assessment	Y N
  
- d. Have you ever had any of the following:

Wisdom tooth removal	Y N	Orthodontics	Y N
Root Canal treatment	Y N	Crowns/Bridges	Y N
Mercury fillings	Y N	Tooth-colored fillings	Y N
  
- e. Have your parents ever experienced tooth loss?
  
- f. Are you concerned about the condition or appearance of your teeth?
  
- g. Do you plan on keeping your teeth for the rest of your life?

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

\_\_\_\_\_  
For Office Use Only  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Brock A. Van Gordon D.M.D., P.C.

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## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and, the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**TREATMENT:** We may use or disclose your health information to obtain payment for services we provide to you.

**PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you.

**HEALTHCARE OPERATIONS:** We may use and disclose your health information in connection with our healthcare operations. Healthcare professionals include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**YOUR AUTHORIZATION:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization, you may revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**TO YOUR FAMILY AND FRIENDS:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with you healthcare or with payment for you healthcare, but only if you agree that we may do so.

**PERSON INVOLVED IN CARE:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your Health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**MARKETING HEALTH-RELATED SERVICES:** We will not use your health information for marketing communications without your written authorization.

**REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law.

**ABUSE OR NEGLECT:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**NATIONAL SECURITY:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence. Counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

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#### PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expense such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.05 (Cents) for each page, \$20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but, if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (e-Mail), you are entitled to receive this Notice in written form.

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#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Kendra L. Leggs

Telephone: 503-682-2455 Fax: 503-570-8852

E-mail: [Kendra@vangordon.com](mailto:Kendra@vangordon.com)

Address: 30045 SW Parkway Avenue, Wilsonville, OR 97070