



Benjamin C. Wang, DMD, PC
610 SW Alder Street Suite #1105
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Welcome Agreement

Welcome to our family of patients. We are delighted you have chosen the Centerport Dental team to provide you with your oral health care. We are committed to providing you with the highest quality dentistry, and look forward to building a partnership to keep you and your smile as healthy as possible.

As a courtesy to you, we gladly process your insurance claims and provide you with an estimate of your co-pay for each visit. Each estimate is based off information given to us by your insurance carrier and is only an estimate. Ultimately you are responsible for any charges not paid by your plan. Please read your insurance benefit booklet and understand all waiting periods, frequency limitations, exceptions, and exclusions. Please know that we do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their portion within 60 days from the start of your treatment, you are responsible for payment at that time.

We ask that if you must cancel a scheduled appointment that you kindly give **48 hour notice**. Dr Wang and the entire staff spend valuable preparation time arranging every detail for your visit. With respect to the staff that serves you and other patients who depend on us, we appreciate timely cancellation notifications and alerts if you are running late. If sufficient notice is not received there is a customary fee of \$50.00 for a missed hygiene appointment and a \$100.00 fee for a missed treatment appointment.

We collect all out of pocket expense in full on the date of service. If you have a financial concern, we are happy to share with you our Care Credit payment plan options. There are no interest options available as well and low interest extended plans designed to fit every budget.

We look forward to getting to know you better through the years to come, and happily welcome you to our practice.

I acknowledge that I understand the information listed above and consent to the welcome agreement.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to the Patient: _____

DENTAL HISTORY

Patient Name _____ Date of Birth _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____ / ____ / ____ Date of most recent x-rays ____ / ____ / ____
 Date of most recent treatment (other than a cleaning) ____ / ____ / ____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] YES NO
2. Have you had an unfavorable dental experience? YES NO
3. Have you ever had complications from past dental treatment? YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? YES NO
6. Have you had any teeth removed or missing teeth that never developed? YES NO

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? YES NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? YES NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? YES NO
10. Is there anyone with a history of periodontal disease in your family? YES NO
11. Have you ever experienced gum recession? YES NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? YES NO
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? YES NO



14. Have you had any cavities within the past 3 years? YES NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? YES NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? YES NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? YES NO
18. Do you have grooves or notches on your teeth near the gum line? YES NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? YES NO
20. Do you frequently get food caught between any teeth? YES NO

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) YES NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? YES NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? YES NO
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? YES NO
25. Are your teeth becoming more crooked, crowded, or overlapped? YES NO
26. Are your teeth developing spaces or becoming more loose? YES NO
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? YES NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? YES NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? YES NO
30. Do you clench your teeth in the daytime or make them sore? YES NO
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? YES NO
32. Do you wear or have you ever worn a bite appliance? YES NO



33. Is there anything about the appearance of your teeth that you would like to change? YES NO
34. Have you ever whitened (bleached) your teeth? YES NO
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? YES NO
36. Have you been disappointed with the appearance of previous dental work? YES NO

MEDICAL HISTORY

Patient Name _____

Name of Physician/and their specialty _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis	<input type="checkbox"/>	<input type="checkbox"/>
2. An allergic reaction	<input type="checkbox"/>	<input type="checkbox"/>	28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			29. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			30. contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			31. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			32. epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfalocal			33. neurologic disorders (ADD/ADHD, prion disease)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> anesthetic			34. viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			35. any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver,) latex			36. hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other			37. STI / STD / HPV	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type)	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO)			40. tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement)	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol / recreational drug use	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5)	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema, shortness of breath, sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency	<input type="checkbox"/>	<input type="checkbox"/>	54. considered atouchy / sensitive person	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs	<input type="checkbox"/>	<input type="checkbox"/>	56. taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c =)	<input type="checkbox"/>	<input type="checkbox"/>	57. currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	58. prostate disorders	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. celiac disease, gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>			
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient Information:

Address: _____

City, State & Zip: _____

Cell & home phone number: _____

Email: _____

Occupation or Place of work: _____

Patient's Signature _____ **Date** _____



Health Consent

Section A: Patient Giving Consent:

Name: _____

Section B: To The Patient—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, at any time.

Contact Person: Any staff member of Benjamin C. Wang, DMD, PC

Phone: (503) 228-1506 **Fax:** (503) 228-1499

Email: admin@centerportdental.com

Address: 610 SW Alder Street Suite #1105, Portland, OR 97205

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT



Sleep Apnea Survey

- YES NO Do you snore?
- YES NO Have you or anyone observed you stop breathing or gasp during sleep?
- YES NO Do you wake up tired or fatigued?
- YES NO Do you doze off easily?
- YES NO Do you ever wake up out of breath, gasping or coughing?
- YES NO Are you a restless sleeper?
- YES NO Do you ever have indigestion or acid reflux?
- YES NO Do you have headaches or jaw pain?
- YES NO Do you have or ever had in the past high blood pressure?
- YES NO Do you have night sweats?

****Three or more YES answers to these questions means you should be further evaluated for Sleep Apnea. Five (5) or six (6) YES answers means there is a very good possibility you have Sleep Apnea****