Dr. LAMPEE™

Patient Information

Name_____ Preferred Name_____

Address_____ Unit_____

City_____ State_____ ZIP_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____ Date of Birth (mm/dd/yy)_____

Why are you here today?_____

How Did you Hear About us?

- ☐ TV Commercial
- ☐ Good Day Oregon
- ☐ AMNW
- ☐ Social Media
- ☐ Internet
- ☐ Radio
- ☐ Drive By / Sign Outside
- ☐ Youtube/Streaming
- ☐ Word of Mouth
  Who: _____
- ☐ Other:_____

Emergency Contact

Name_____

Home Phone_____ Work Phone_____ Cell Phone_____

Relationship to Patient: Parent / Guardian / Spouse / Other:_____

Phone | 503-646-2273
Fax | 503-277-1535

www.drlampee.com

14455 S.W. Allen Boulevard, Suite 103
Beaverton, Oregon 97005

Dr. LAMPEE™
IMPLANTS | VENEERS | LASER

Patient Medical History

Name_____ DOB_____

Physician's Name_____

☐ Check if you are under medical treatment now.

If checked, what for?_____

☐ Check if you are or have ever been hospitalized for any surgical procedure or serious illness.

☐ Check if you are taking any medication(s) including non-prescription.

If checked, what medication(s) or supplements) are you taking?_____

_____

☐ Check if you use tobacco / cannabis products. If yes, what type & how often?_____

☐ Check if you use alcohol. If yes, what type & how often?_____

☐ Check if you have a history of drug or alcohol abuse. If checked please specify?_____

☐ Check if you have taken or are currently taking bisphosphonates.

☐ Check if you have had bariatric surgery. If checked, please specify type & date _____

Are you allergic to or have you had any reaction to the following? Check all that apply.

☐ Topical Anesthetics
☐ Local Anesthetics
☐ Latex
☐ Aspirin
☐ Tylenol
☐ Ibuprofen (Advil)
☐ Prescription Pain Medications
☐ Sulfa Drugs
☐ Penicillin
☐ Sedatives

Other:_____

Phone | 503-646-2273
Fax | 503-277-1535

www.drlampee.com

14455 S.W. Allen Boulevard, Suite 103
Beaverton, Oregon 97005

Dr. LAMPEE™

Patient Medical History
continued

Do you or have you had any of the following? Check all that apply.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder_____
- ☐ Blood Pressure - High
- ☐ Blood Pressure - Low
- ☐ Blood Thinners
- ☐ Cancer
  - Area_____
  - Year_____
- ☐ Chest Pains
- ☐ Cold Sores
- ☐ Convulsions
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type I or II. Last A1c_____
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Frequently Tired
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type A / B / C
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mental Illness_____
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation
  - Area_____
  - Year_____
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Weight Loss
- ☐ Other:_____

Women Only. Check if you are:

- ☐ Pregnant
- ☐ Nursing
- ☐ Taking birth control pills

Patient Consent Agreement

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information may be dangerous to my health. I hereby authorize and request the performance of dental services for myself and/or for:

Name_____

I authorize and give consent to perform dental services agreed upon between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated.

Patient or Guardian Signature_____ Date_____

Phone | 503-646-2273
Fax | 503-277-1535

www.drlampee.com

14455 S.W. Allen Boulevard, Suite 103
Beaverton, Oregon 97005

Policy Acknowledgment

We are committed to providing you with the best possible dental care. In order to achieve this we need your assistance and your understanding of our payment policies.

Financial Information

- We accept the following major credit/debit cards: Visa, Mastercard, Discover, and American Express.
- For those who desire a payment plan, we are partnered with Care Credit, Lending Club, and Proceed Financing. These payment plans are based on your approved credit. There are no application fees. These arrangements must be made prior to treatment.
- Payment for treatment is due at time of service. If you are requiring sedation, payment is due upon scheduling the appointment.
- We do not contract or bill insurance.
- Balances over 90 days will be assigned to a collection agency and will incur a $50.00 collection fee. Any checks returned to our office for non-sufficient funds will be subject to a fee of $25.00.

Usual and Customary Rates

We charge what is usual and customary for our area. Please be aware that some of the services we provide may not be covered services by your dental plan. You are responsible for payment regardless of your insurance company's exclusions and fee schedules. Your insurance policy is a contract between you and that insurance company. We are not able to negotiate with your insurance company on your behalf.

I have read the Policy Acknowledgment and understand that as a patient, or responsible party, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of this office as stated above.

Patient Signature or Responsible Party _____ Date _____

Missed Appointment Policy

We require two business days' notice to reschedule an appointment. Our business days are Monday–Thursday.

- There is no fee for your first missed appointment. We understand that life happens.
- There is a $50 fee for your second missed appointment.
- There is a $100 fee for your third missed appointment.
- Additional missed appointments will result in us not being to see you as a patient.
- If a sedation appointment or appointment lasting two or more hours is missed or rescheduled with less than two business days' notice, 10% of your appointment cost is non-refundable

Patient Signature or Responsible Party _____ Date _____

Phone | 503-646-2273
Fax | 503-277-1535

www.drlampee.com

14455 S.W. Allen Boulevard, Suite 103
Beaverton, Oregon 97005

Dr. LAMPEE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Our policy is on our website and we will provide with you a physical copy by request

Federal law requires that we offer to provide you with a copy of our Notice of Privacy Practices.

The Notice of Privacy Practices explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Notice of Privacy Practices, please feel free to direct these to our Privacy/Security Officer at any time. The name and contact number of the Privacy/Security Officer is listed on your copy of the Notice of Privacy Practices

Patient Name:_____ Date of Birth:_____

Patient to complete this section

I have been offered a copy of the Notice of Privacy Practices for this organization on today's date.

Signed:_____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Notice of Privacy Practices was provided to

Patient Name:_____ On _____

The patient was unable/unwilling to acknowledge receipt of the Notice of Privacy Practices for the following reason:

_____
_____
_____

Signed:_____