Date: _____

Patient Intake Form

Patient Name: _____ D.O.B._____

Legal Sex (as listed on govt. ID / insurance policy): Female☐ Male☐ X☐ _____☐

Race/Ethnicity:

Caucasian ☐ Latino or Hispanic ☐ Black or African American ☐ Middle Eastern ☐ South Asian ☐ East Asian ☐

Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ _____ ☐

Health History

General Health History

Do you have any of the following conditions: (Select all that apply)

ADD/ADHD	☐	Heart Rhythm Abnormalities	☐
Anxiety	☐	History of Heart Attack	☐
Depression	☐	History of Stroke	☐
Autism	☐	Blood Clotting Problems	☐
Mental Health Problems	☐	Blood Disorders	☐
Thyroid Condition	☐	Hepatitis	☐
Cancer	☐	Liver Disease	☐
Hayfever/Seasonal Allergies	☐	Fever Blisters/Herpes	☐
Chronic Sinusitis/Sinus Congestion	☐	Aids/HIV Infection	☐
Asthma	☐	Tuberculosis	☐
Shortness of breath	☐	Other Contagious Disease	☐
Chronic Obstructive Pulmonary Disease	☐	Kidney/Bladder Trouble	☐
Difficulty Swallowing	☐	Sexual Problems	☐
Acid Reflux/Heartburn	☐	Dry Mouth/Dry Eyes	☐
Stomach Ulcers	☐	Gum (periodontal) Disease	☐
Irritable Bowel Syndrome	☐	Fainting Spells/Seizures	☐
Diabetes	☐	Epilepsy	☐
High Cholesterol	☐	Joint Replacement	☐
High Blood Pressure/Hypertension	☐	Trauma/Injury to Face	☐
Low Blood Pressure/Hypotension	☐	Tinnitus/Ringing in the ear(s)	☐
Cardiac Pacemaker	☐	TMJ Pain	☐
Heart Valve Replacement	☐	Fibromyalgia/Chronic Body Pain	☐
Heart Disease	☐	Shoulder Pain/Neck Pain	☐

Headaches & Migraines

Do you get headaches? Yes ☐ No ☐

If yes, how often _____

What triggers the headache? _____

What relieves headache? _____

Describe headache: Dull ☐ Aching ☐ Thunderclap ☐ Sharp ☐

What part of the head? Forehead ☐ Behind eyes ☐ One Side only ☐ Sides of the head ☐ Top of the Head ☐

Allergies

Latex	☐	Pain Medications	☐
Metal	☐	Plastic	☐
Acrylic	☐	Food	☐
Contrast Dye	☐	Antibiotics	☐

List all other allergies: _____

_____

_____

_____

Sleep Health History

Do you have any of the following conditions: (Select all that apply)

Snoring	☐	Obstructive Sleep Apnea	☐
Excessive Daytime Sleepiness	☐	Central Sleep Apnea	☐
Insomnia	☐	Narcolepsy	☐
Restless Leg Syndrome	☐	Periodic Limb Movement	☐
Sleep Walking	☐	Bed Wetting	☐
Night Terrors	☐	Circadian Rhythm Disorder	☐

Have you ever had a sleep study? Yes ☐ No ☐

Approximate date of most recent sleep study: _____

Location of most recent sleep study: _____

Have you currently or previously used any of the following treatments for OSA?

	Current	Past
Mandibular Advancement Device Hypoglossal	☐	☐
nerve stimulation (INSPIRE)	☐	☐
CPAP	☐	☐
Myofunctional Therapy	☐	☐
Airway Surgery	☐	☐
Tongue Tie and/or Lip Tie Release (frenectomy)	☐	☐

Care Providers

Do you have a Primary Care Provider (including Pediatrician)? Yes ☐ No ☐

If yes:

Name of Primary Care Provider _____

Location of Primary Care Provider _____

Do you have a Sleep Specialist or ENT? Yes ☐ No ☐

If yes:

Name of Sleep Specialist or ENT _____

Location of Sleep Specialist or ENT _____

Medication

Do you take any of the following medication types at least once a week?

Blood pressure medication	☐	Chemotherapy agents (IV or oral)	☐
Pills for diabetes	☐	Sleeping medication	☐
Depression medication	☐	Insulin	☐
ADHD medication/stimulants	☐	Pain medication	☐
Sexual function stimulant	☐	Anxiety medication	☐
Thyroid medication	☐	Bladder urge suppressant	☐
Antihistamine or steroid for nasal congestion	☐	Cannabinoids (THC or CBD)	☐
		Home Oxygen	☐

List any medications (prescriptions, OTC, herbal supplements): _____

_____

_____

Are you required to pre-med with antibiotics before dental treatment? Yes ☐ No ☐

Patient Intake Form

Health History

Surgeries/Hospitalizations

Have you had any surgery on the following body parts or types?

Nose ☐	Weight Loss Surgery ☐	Neck ☐
Tongue ☐	Sinus ☐	Lungs ☐
Palate/Lips ☐	Jaw ☐	Brain ☐
Back (spine) ☐	Tonsils/Throat ☐	TMJ ☐
Sleep Apnea ☐	Adenoids Removed ☐	Teeth ☐

List ALL previous surgeries or procedures below (include year):

_____

_____

Are you planning on any upcoming surgeries or procedures? Yes ☐ No ☐

Details: _____

_____

Have you been hospitalized within the past 5 years? Yes ☐ No ☐

If yes, what illness or problem? _____

_____

Dental & Orthodontics

Are you planning on any upcoming dental work? Yes ☐ No ☐

Details of upcoming dental work: _____

_____

Are you currently undergoing any orthodontic treatment? Yes ☐ No ☐

Name of orthodontist or specialist _____

Location of orthodontist or specialist _____

Have you undergone orthodontics in the past (i.e. braces, aligners, expanders, etc.)? Yes ☐ No ☐

If Yes, how many times? 1 ☐ 2 ☐ 3+ ☐

In what year(s)? _____

Have you ever had IPR (slimming teeth in ortho)? Yes ☐ No ☐

Have you ever had headgear? Yes ☐ No ☐

If yes, in what year(s)? _____

Were permanent teeth removed as part of your orthodontics? Yes ☐ No ☐

Family & Social

Family History (Select all that Apply)

High Blood Pressure ☐	Heart Disease ☐
Diabetes ☐	Obesity ☐
Cancer ☐	Stroke ☐
Snoring ☐	Sleep Apnea ☐
Insomnia ☐	Restless Leg Syndrome ☐
Anxiety ☐	Depression ☐

Family History Details: _____

Do you now, or have you ever, smoked? Yes ☐ No ☐ Current ☐

How many packs of cigarettes per week? _____

Do you consume alcohol? Yes ☐ No ☐

How many drinks per week? _____

Do you regularly consume caffeine or sugary drinks like soda? Yes ☐ No ☐

How often? _____

Do you now, or have you ever, vaped? Yes ☐ No ☐

If yes, what type of vaping product? _____

How often? _____

Who sleeps in the same room with you (select all that apply)?

Spouse ☐	Other family member ☐
Partner ☐	I sleep alone ☐
Roommate ☐	Pet ☐

Do you have pets? Yes ☐ No ☐

If yes, how many and what type of pets? _____

Are you currently or planning to become pregnant? Yes ☐ No ☐

Patient Intake Form

Dental History

When was your last dental visit? _____

Date of last radiographs (x-rays): _____

How many dentists have you seen in the last 5 years?

0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐

What is your immediate dental need, if any?

_____

Are you happy with your smile?

_____

Is there any aspect of your smile you hope to correct?

_____

Has anything prevented you from addressing this concern in the past?

_____

Does dental treatment make you nervous?

Extremely ☐ Moderately ☐ Slightly ☐ No ☐

Have you ever had cavities or other dental concerns?

Yes ☐ No ☐

If Yes, please explain: _____

Do you have any of the following?

Bleeding gums	☐	Food impactions	☐	Orthodontic treatment	☐
Loose teeth	☐	Sensitivity to pressure	☐	Unpleasant taste/bad breath	☐
Sensitivity to cold	☐	Bite your cheeks/lips	☐	Gum recession	☐
Sensitivity to heat	☐	Difficulty opening or closing jaw	☐	Gum disease	☐
Burning tongue/lips	☐	Clicking/popping in the jaw	☐	Teeth removed for braces	☐
Swelling or lumps in the mouth	☐	Clenching or grinding	☐	Wisdom teeth removed	☐
Frequent blisters on lip/mouth	☐	Change in bite or multiple bites	☐	Change in teeth shape/length	☐
Sensitivity to sweets	☐	Shifting teeth	☐	Bruxism	☐

Other: _____

How often do you brush? _____

Your toothbrush is:

Soft ☐ Medium ☐ Hard ☐

Do you use the following?

Manual toothbrush	☐	Dental Floss	☐	Breath mints/Altoids	☐
Electric toothbrush	☐	Mouthwash	☐	Fluoride Rinse	☐

EVOLUTION DENTAL

New Patient Registration

Patient Name: _____ Date of Birth: ____/____/_____

Address: _____ City/State/Zip: _____

Phone Number: _____ *Cell / Home* **Drivers License: _____**

Pronouns: _____ Legal Sex (on insurance forms): M / F / X

Email Address: _____

Preferred Pharmacy: _____

Phone Number: _____ Main Cross Streets: _____

Emergency Contact Name: _____

Relationship to patient: _____ Phone Number: _____

Guarantor Information - If Different From Patient

Name: _____ Relationship to patient: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ *Cell / Home* **Pronouns: _____**

Email Address: _____ Date of Birth: ____/____/_____

☐ **Please check this box if you give us, Evolution Dental staff and team, permission to discuss your treatment and financial arrangements with this person. Signature of patient: _____**

EVOLUTION DENTAL

Consent for Photography or Video Release

At Evolution Dental, we prefer to document all services and treatments performed. New patient exams start with a series of photographs. This baseline record provides a useful reference point throughout your treatment. We also take before and after photos and provide those to you if desired so that you may have a record of your own progress. At times we may wish to share these photos with other providers for additional review for the purpose of ensuring that our patients receive the best possible care and experience the best treatment outcomes. You are not required to sign this release form.

I, the patient/guardian (the "Releasor"), grant permission and consent to the listed Provider (the "Releasee") for use of the photograph(s) or video content taken during any of the office visits for presentation under any legal condition including but not limited to: illustration, educational purposes, educational web content, and as part of the normal course of operations of the practice such as in coordination with a laboratory or supporting organization who may provide clinical guidance or resources to aid the Provider in treatment management. **Consent is granted for the following (please check one):**

- ❑ Both intra-oral (inside the mouth) and extra-oral (face / body / external) images
- ❑ Intra-oral only
- ❑ Extra-oral only
- ❑ **I do not consent**

This authorization and release shall also apply to the benefit of the legal representatives and licensees of Dr. Russell Teasdale and Evolution Dental.

- ❑ I am over the age of eighteen
- ❑ I have read and fully understand the terms of this release.

Releasor Name : _____
Patient or Guardian **Name**

Releasor Signature: _____
Patient or Guardian **Signature**

Date: _____

EVOLUTION DENTAL

RECORDS RELEASE REQUEST

To Releasing Doctor or Physician: _____

Phone number: _____

Fax number: _____

Doctor Address: _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Evolution Dental
Dr. Russell C. Teasdale, DMD
1316 SW 13th Avenue Suite B ● Portland, Oregon 97201
Office: (503)974-3829 ● Fax: (886)316-3136

Please email to: hello@evolutiondentalpdx.com

Please send most current:

□ CBCT Scan: _____

□ Sleep Study and interpretation/diagnosis: _____

□ Any information pertaining to tooth # _____

□ Other _____

_____

Patient First and Last Name Date of Birth

_____

Patient or Responsible Party Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I _____(printed name) have been informed of the Notice of Privacy Practices for Evolution Dental.

_____
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 acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

  _____

  _____

  _____

Evolution Dental, P.C.
1316 SW 13th Ave Suite B
Portland
Oregon, 97201

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Evolution Dental, P.C. understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 03/21/23, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 disclosures permitted by your authorization while it was in effect. 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 another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons 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 care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of

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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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 authorized 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.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

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 expenses such as copies, mailing, 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 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 at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under 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.

Records Transfer: If a healthcare practice where your health information records reside is sold or merges with another practice or organization, your records will be transferred to the new owner. However, you may request that copies of your health information be transferred to another practice.

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.

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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Claire Frazier
Telephone: (503)974-3829
E-mail: hello@evolutiondentalpdx.com
Address: 1316 SW 13th Ave Suite B
Zip Code: 97201
State: Oregon
City: Portland

Financial Policy & Agreement

Payment Options & Financial Arrangements

We recognize that patients have differing needs when it comes to fulfilling financial obligations. We accept the following payment methods for payment in full: **American Express, Discover, Mastercard, Visa, HSA/FSA, cash, and check**. A **$45 fee** will be assessed for any returned checks.

Layaway plans, payment plans, and third-party financing may be available for qualifying treatment plans pending credit approval. **All payment arrangements must be made at the time of treatment acceptance.**

Insurance Billing

Evolution Dental is an **out-of-network provider with all medical insurance plans**. We do not accept insurance assignment, meaning we are not paid directly by health insurance and we cannot anticipate the dollar amount that will be paid by insurance following a claim submitted on behalf of a patient. For this reason, **full payment must be arranged between the patient (or guarantor) and Evolution Dental at the time of service**.

As a courtesy, when appropriate, we will submit insurance claims on your behalf for out-of-network benefits within the timely filing window. While we will work with you to help maximize available benefits, **we are not a financial institution and cannot guarantee insurance participation in the cost of your care**.

Insurance payments are to be made **directly to the patient**, not to our office.

In some cases, we may be **in-network with your dental insurance plan**. If applicable, we will review your treatment plan against your policy and adjust upfront costs accordingly. **Patients remain ultimately responsible for payment in full** if insurance fails to pay the anticipated amount for any reason.

New Patient Booking Fee

A booking fee is required for all new patients at the time of scheduling and will be applied toward the first appointment.

- **$250** for a 90-minute new patient consultation
- **$150** for all other first-visit appointments

Booking fees may be transferred or refunded **only if our office receives notice to cancel or reschedule during business hours at least two (2) business days in advance**, in accordance with the section below on rescheduling, cancellations, and missed appointments.

Appointment Rescheduling, Cancellation & Missed Appointments

Because our practice operates with a single operatory, **each appointment time is reserved exclusively for the scheduled patient.** Missed or late-cancelled appointments cannot be filled on short notice and directly impact our ability to care for other patients.

Notice Requirements

A minimum of **two (2) business days (48 hours)** notice is required to cancel or reschedule an appointment. Cancellations received at least two business days in advance **will not incur a fee**.

Cancellation notices are considered received **only during business hours**, which are **Monday–Thursday, 8:00 AM–5:00 PM**. Messages left outside of business hours (evenings, weekends, or holidays) will be processed on the next business day.

Missed (No-Show) Appointment Fees:

- **$250** for new patient consultations
- **$150 per hour** for all other appointments (rounded to the nearest hour)

Late Cancellation Fees (less than two business days' notice):

- **$250 late cancellation fee** for new patient consultations
- **$100 late cancellation fee** for all other appointments

All fees must be paid **prior to rescheduling**. Repeated late cancellations or no-shows may result in placement on a **last-minute-only scheduling list** and/or a requirement to **pay in full at the time of booking**. Please note that insurance companies do **not** cover missed appointment or cancellation fees.

Special exceptions may be considered on a **case-by-case basis** for sudden illness or family emergencies. We appreciate your help in keeping our small team healthy by staying home if you are ill.

Refund Policy

The availability and amount of any refund depend on multiple factors, including but not limited to: amounts paid, amounts owed, costs already incurred by our office, and insurance claims that have been submitted or processed. Custom treatments may include non-refundable laboratory fees. Doctor chair time already utilized is non-refundable. Refunds are reviewed **on a**

case-by-case basis and are issued **once per month**. To be eligible for any refund, a patient must **formally discontinue the treatment in question** prior to a refund being considered.

Acknowledgment

A signed copy of this document is required prior to the first appointment. By signing below and scheduling an appointment with our office, you acknowledge you have read, understand, and agree to each of the above terms of the Financial Policy.

_____
Patient Name

_____
Patient Signature

_____
Date

Please complete the section below only if the financial guarantor (party responsible for payment) is other than the patient and/or if the patient is under the age of 18.

_____
Guarantor Name

_____
Guarantor Signature

_____
Date