Patrick Sherrard DMD, PC
your smile, portland-style

9053 SW Beaverton-Hillsdale Hwy
Portland, OR 97225

503.246.4712
facebook.com/DrSherrard
www.DrSherrard.com

Dear Patient,

When you reserve time in our schedule with our hygienist or myself, we are committed to seeing you in a timely manner in order to provide the treatment you desire. Because this time has been reserved for you, it is not available to other patients. Consequently, if you do not honor that time, not only have you lost an opportunity to receive your treatment, but our other patients have also lost theirs. This can also delay your next appointment.

I, _____, understand that it is the policy of Dr. Sherrard to assess a $50.00 fee to all appointments that are missed without a 24-hour cancellation notice (not including Fridays and holidays).

_____ _____

Patient Signature Date

Patrick A. Sherrard, DMD, PC

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WRITTEN FINANCIAL POLICY

Thank you for choosing Patrick Sherrard, DMD, PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

Cash, Check, Visa, MasterCard, or American Express

We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $300 or more.

Convenient monthly payment plans from Care Credit [1]

- Allow you to pay over time
- Have no annual fees or prepayment penalties

Flexible dental financing is also available through Compassionate Healthcare Services [2]

- Allows you to choose your own monthly payments

Please Note:

Patrick Sherrard, DMD, PC, requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Patrick Sherrard, DMD, PC, charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ _____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

1 Subject to credit approval

2 More information about Compassionate Healthcare Services terms & requirements can be found at http://compassionatehealthcareservices.com

3 However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Patient Information

Welcome to our office. We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name _____ Date of birth _____ Age _____ Sex ☐ M ☐ F

Home address _____ City _____ State _____ Zip _____

Billing address (if different) _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Email _____

SS# _____ Driver's license # _____ State _____

Employer / Occupation _____ Phone _____

Spouse's name _____ Phone _____

Emergency name & phone # (other than spouse) _____

Primary dental insurance _____ Group # _____

Secondary dental insurance _____ Group # _____

Subscriber's name _____ Date of birth _____

Name of your medical doctor _____ Date of last visit to medical doctor _____

Name of previous dentist _____ Date of last visit to dentist _____

Referred to us by _____

Dental Health History

	Y	N
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in/around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Y	N
How often do you brush?		
How often do you floss?		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open it freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon waking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in your face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

Medical History

Do you have, or have you had, any of the following?

	Y	N
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problems	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation / Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Fainting spells	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer / Tumor	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury	☐	☐
Epilepsy, seizures, or other neurological disease	☐	☐
History of alcohol or drug abuse	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		

Do you have any disease, condition, or problem not listed previously that you feel we should know about? ☐ ☐

If so, please describe _____

Are you allergic, or have you reacted adversely, to any of the following?

	Y	N
Local anesthetics (Novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, acetaminophen, or ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other		

During the past 12 months, have you taken any of the following?

	Y	N
Antibiotics or sulfa	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other		

Please list current medications _____

Women

	Y	N
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?	☐	☐

Patient / Parent Signature _____

Dentist Initials _____