



NAME OF PATIENT \_\_\_\_\_  
First Middle Last Birthday Age

Preferred Name \_\_\_\_\_

Resident Address \_\_\_\_\_  
Street No. City State Zip

Mailing Address \_\_\_\_\_  
Street No. City State Zip

Cell Phone No. (\_\_\_\_) \_\_\_\_\_  Home Phone No. (\_\_\_\_) \_\_\_\_\_   
Please check your best contact phone #

Email Address \_\_\_\_\_

**RESPONSIBLE PARTY**

Self/Parent \_\_\_\_\_

Social Security No. \_\_\_\_\_

Driver's License No. \_\_\_\_\_

Cell Phone No. (\_\_\_\_) \_\_\_\_\_

Is there a dental insurance company that you would like us to bill? Primary  Secondary

Whom may we thank for referring you to our office?  
\_\_\_\_\_

IN CASE OF EMERGENCY CONTACT: \_\_\_\_\_  
Name Relationship Phone #

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and / or health practitioners. I give my permission for Select Care Dental to leave messages on my home and/or cell voicemail or with my spouse/partner/caregiver regarding treatment, billing and appointment information. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment or co-payment is due on the day of service.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (Or Parent If Minor)

\_\_\_\_\_  
Date

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you currently under medical treatment now Yes No

or being tested for a medical condition? If yes, please explain \_\_\_\_\_  Yes  No

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

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain \_\_\_\_\_  Yes  No

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

3. Please list any medications or supplements that you are currently taking \_\_\_\_\_  Yes  No

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

4. Do you use tobacco? Frequency \_\_\_\_\_  Yes  No

5. **Dental History:**

Name of Previous Dentist \_\_\_\_\_

Location of Previous Dentist \_\_\_\_\_

Date of Last Exam \_\_\_\_\_

- Have you ever been pre-medicated with antibiotics prior to a dental appointment? If so, why \_\_\_\_\_  Yes  No

Do you feel pain in any of your teeth?  Yes  No

Do you have any sores or lumps in or near your mouth?  Yes  No

Have you had any head, neck or jaw injuries?  Yes  No

Have you ever experienced any of the following problems in your jaw?  Yes  No

Clicking.....  Yes  No  
Pain (Joint, ear, side of face).....  Yes  No

Difficulty in opening or closing.....  Yes  No

Difficulty in chewing.....  Yes  No

- Do you clench your teeth?.....  Yes  No

- Have you ever had any prolonged bleeding following dental extractions?.....  Yes  No

- Do you like your smile?.....  Yes  No

6. Are you allergic to or had any reactions to the following?  Yes  No

- Local Anesthetics (e.g. Novocain) .....  Yes  No
- Penicillin.....  Yes  No
- Other Antibiotics.....  Yes  No
- Codeine.....  Yes  No
- Sulpha.....  Yes  No
- Sedatives.....  Yes  No
- Aspirin.....  Yes  No
- Any Metals, If yes what kind \_\_\_\_\_  Yes  No
- Latex Rubber  Yes  No
- Other Allergies \_\_\_\_\_  Yes  No
- WOMEN ONLY
- Are you pregnant or think you may be pregnant?  Yes  No
- Are you nursing?  Yes  No
- Are you taking oral contraceptives?  Yes  No

7. Do you have or have you had any of the following? Year Diagnosed

- Angina.....  Yes  No
- Arthritis.....  Yes  No
- Asthma.....  Yes  No
- Bisphosphonate Therapy.....  Yes  No
- Cancer..... Type \_\_\_\_\_  Yes  No
- Cardiac Pacemaker.....  Yes  No
- Celiac Disease.....  Yes  No
- Diabetes..... Type \_\_\_\_\_  Yes  No
- Emphysema.....  Yes  No
- Epilepsy/Convulsions.....  Yes  No
- Glaucoma.....  Yes  No
- Heart Attack.....  Yes  No
- Heart Disease.....  Yes  No
- Heart Murmur.....  Yes  No
- Heart Valve Replacement.....  Yes  No
- Hepatitis.... Type \_\_\_\_\_  Yes  No
- High Blood Pressure.....  Yes  No
- High Cholesterol.....  Yes  No
- Aids or HIV Infection.....  Yes  No
- Irritable Bowel Syndrome.....  Yes  No
- Jaundice.....  Yes  No
- Joint Replacement. Type \_\_\_\_\_  Yes  No
- Kidney Disease.....  Yes  No
- Leukemia.....  Yes  No
- Low Blood Pressure.....  Yes  No
- Mitral Valve Prolapse.....  Yes  No
- Osteoporosis.....  Yes  No
- Radiation Therapy.....  Yes  No
- Respiratory Problems.....  Yes  No
- Rheumatic Fever.....  Yes  No
- Seasonal Allergies.....  Yes  No
- Sinus Problems.....  Yes  No
- STD Type \_\_\_\_\_  Yes  No
- Stroke.....  Yes  No
- Thyroid Problems.....  Yes  No
- Tuberculosis.....  Yes  No
- Other, Please List \_\_\_\_\_  Yes  No

Print Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



SELECT CARE  
DENTAL  
*Redmond*

## Office Policies

### APPOINTMENTS

- At Select Care Dental, as a courtesy we will send you a confirmation reminder and appointment reminder. We ask you call us back or that you respond with a “C” to confirm. Unconfirmed appointments may be cancelled with the need to reschedule at a later time.
- As a courtesy, please notify our office if you cannot make your appointment at least 48 hours prior to the scheduled time.
- Any changes to appointments are not accepted by text or email. Please call our office and speak to a team member to make or change an appointment.
- For patients with a history of missing or canceling appointments at the last minute, a deposit may be required to secure a future appointment and/or become same day only.
- If you arrive 10+ minutes late for your scheduled appointment, you may be asked to reschedule. This is done out of respect for our other patients with scheduled appointments. Please call ahead to let us know if you are running late, and we will do all we can to still accommodate you when our schedule permits.

### DENTAL INSURANCE

- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement on your behalf.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select services they will and will not cover.
- Our computer software makes an “**estimate**” of what your insurance will cover, and the balance will be your out-of-pocket cost. **This is only an estimate**, and it is possible that your insurance may cover less than what is estimated. If your insurance does not pay the estimated benefit in full, **you will be immediately responsible for any remaining balance.**
- Any estimated out of pocket balances, deductible, or coinsurance is **due on day of service.**
- If we do not receive payment from your insurance carrier within 60 days, **you will be responsible for payment of any balance due.**

### OUT OF NETWORK INSURANCE

- Payment is **due in full on day of service**
- For patients with dental insurance that we are not in-network, we are happy to send a claim as a courtesy to your insurance company, and **they will reimburse you directly.**
- We cannot give estimates for what the insurance company will reimburse you.

**FINANCIAL POLICY**

- All payments are **due in full on day of service.**
- Forms of payments we accept:  
Cash, Checks, Money Orders, Credit/Debit Cards (Visa, MasterCard, Discover, American Express, and Care Credit)
- Care Credit, Cherry and Proceed Financing are companies that offer interest free payment options as well as long term interest payment options. This is a company not affiliated with Select Care Dental and we do not have any control over acceptance in this program. We will assist you in the application process as much as we possibly can.
- For any returned checks there will be a returned check fee of **\$50** charged to your account.
- Patient acknowledges and agrees that **all accounts past 30 days may bear a compounding interest rate of 1.5% per month.** In the event that the patient does not pay for performed services, Select Care Dental may place patient’s account with a collection agency. The patient further agrees to pay reasonable collection fees, attorney fees, and court costs incurred in collection of an overdue account.
- Patients who have had their accounts turned over to collections will no longer be considered active in the dental practice and will only be seen on a cash basis once the balance has been taken care of with the collection agency.

**REPOSIBLE PARTY**

- As the responsible party, in the case where any spouse and/or children are also patients at Select Care Dental, these office policies will apply to them and their accounts as well.

**By signing below, I acknowledge and agree to all the above policies of Select Care Dental**

Print Name:

Date:

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Signature:

Date:

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SELECT CARE  
**DENTAL**  
*Redmond*

## Permission to Disclose Patient Information

We may disclose your finances, dental, and health that may include HIPAA's special protections (HIV/AIDS, mental, genetic and substance use disorder information) to a family member, personal representative, friend or other 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**. Please list the individuals below who have your permission to share your health information:

Name	Relationship to Patient

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**PATIENT CONSENT TO RELEASE RECORDS**

I, \_\_\_\_\_, give my consent for the office of \_\_\_\_\_ to release my dental radiographs and dental records that may include HIPAA's Special Protections (HIV/Aids, Mental Health, Genetic, and substance use disorder information) to Dr. Jared R. Anderson and Mark T. Nuttall.

Name of Patient:

DOB:

Address:

Telephone #:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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

Personal Representative Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
Date consent sent: \_\_\_\_\_

Authorized representative of the Select Care Dental Team: \_\_\_\_\_

**PLEASE EMAIL RECORDS TO [OFFICE.SELECTCARE@GMAIL.COM](mailto:OFFICE.SELECTCARE@GMAIL.COM)  
774 SW RIMROCK WAY REDMOND, OR 97756  
PHONE (541) 923-7633 FAX (541) 923-8733**



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*Redmond*

## X-Ray and Exam Protocol

Each patient's preventive treatment is determined by individual patient need. Patient need is determined by several different factors, such as: periodontal disease, caries risk, and existing restorations.

### Exams:

Dr. Anderson's and Dr. Mark's standard of care requires that each patient has an examination by one of the doctors once a year OR at every other hygiene visit. Although each of our hygienists are very skilled, knowledgeable and highly qualified in dental hygiene they CAN NOT legally diagnose dental treatment.

### X-Rays:

Dr. Anderson's and Dr. Mark's standard of care recommends that patients have annual bite wing x-rays (BWX) and/or Periapical (PA) in order to assist the doctor in diagnosing decay that is not visible to the eye. BWX-rays show decay between back teeth (molar and premolar). PA-rays are for the front teeth or a specific tooth. These BWX and PA's also show the hygienist bone levels around your teeth and will help in diagnosing the presence, severity and progression of periodontal disease. Some insurances will downgrade BWX and PA combo to a panoramic, and it may become an out-of-pocket cost.

Every 3-5 years the doctor's standard of care recommends that patients have a 3D full mouth image. This show decay in the roots of teeth, bone levels, third molars (wisdom teeth) and tooth development in children. The doctors use these x-rays to diagnose decay, cysts, tumors, abscesses, periodontal disease, failing restorations and anomalies. Some insurances will not cover 3D images and it may become an out-of-pocket cost.

The dentist and dental hygienist evaluate each patient for necessary x-rays. The necessity of which x-rays are taken is determined by each patient's oral health. Not all patients fall into the above recommendations.

*"The Standard of Care in Oregon requires that current radiographs are available prior to providing treatment to a patient. If a patient without a medical justification refuses to allow radiographs to be taken, even with the offer to sign a waiver, then providing treatment to that patient would violate the Standard of Care in Oregon." ~Oregon Board of Dentistry*

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your continued patronage with the Select Care Dental team!



Effective Date: February 9, 2026

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We take our responsibility to safeguard your protected health information very seriously. We value your trust

as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your provider.

This notice describes how your medical information may be used and disclosed and how you can access this information. Please review it carefully.

### **How We May Use and Disclose Your Information**

We may use and disclose health information about you without your permission for the following reasons:

1. For Treatment: To coordinate or manage your care with other providers or facilities.
2. For Payment: To obtain reimbursement from insurance for services provided.
3. For Healthcare Operations: To improve our services, manage our practice, train staff, and perform audits.
4. For Legal Requirements: When required by federal, state, or local law.
5. To Prevent Serious Threats: To protect your health and safety or the health and safety of others.
6. For Public Health and Safety: Including disease prevention, abuse reporting, and FDA oversight.
7. For Research: When reviewed and approved under a special process.
8. For Workers' Compensation and Law Enforcement: When required under these programs.
9. With Family or Friends: If involved in your care and based on your preference or best interest.

We will only share the minimum necessary information needed for each purpose.

We will not use or disclose your health information for marketing, sale, or fundraising without your written authorization. You may revoke this authorization at any time in writing.

### **Special Protections: Substance Use Disorder (SUD) Records**

If your medical record includes information related to substance use disorder treatment protected under federal law (42 CFR Part 2), that information has additional privacy protections:

- We will not disclose it without your written consent unless required by law.
- It may not be used in court or legal proceedings without a special court order.
- You may revoke your consent at any time.
- Any re-disclosure of this information by others may no longer be protected.
- You have the right to opt out of any fundraising communications.

### **Special Protections Under Oregon Law**

Oregon law provides additional privacy protections for certain types of health information.

These laws may limit how we use or disclose this information, even when disclosure would otherwise be permitted under federal law (HIPAA).

**This includes:**

- HIV/AIDS and HIV testing information (ORS 433.045), which may not be disclosed without your specific written authorization except as permitted by law.
- Mental health treatment information (ORS 179.505–179.509), which may have additional restrictions on use and disclosure.
- Genetic information (ORS 192.531–192.549), which is subject to special confidentiality protections.
- Substance Use Disorder treatment records protected under federal law (42 CFR Part 2), as described above.

**Your Rights**

You have the right to:

- Access: Ask to see or get a copy of your health and billing records.
- Amend: Ask us to correct your records if you think they’re incorrect.
- Request Restrictions: Ask us not to use or share certain information. We are not required to agree but will consider your request.
- Request Confidential Communications: Ask us to contact you in a specific way (e.g., only at work, no voicemail).
- Accounting of Disclosures: Ask for a list of when we shared your information for reasons other than treatment, payment, or healthcare operations.
- Get a Copy of This Notice: You can request a paper copy at any time.
- Be Notified of a Breach: You will be notified if a breach occurs that may have compromised your protected health information.

To exercise any of these rights, contact our Privacy Officer using the details at the bottom of this page.

**Our Responsibilities**

We are required by law to:

- Keep your health information private.
- Provide you with this Notice.
- Follow the terms of this Notice.
- Notify you if a breach of your protected information occurs.

We may change our privacy practices and update this Notice. If we do, the new terms will apply to all health information we maintain. We will post the updated Notice in our office and on our website, and make copies available upon request.

**Complaints and Questions**

If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint. Contact for complaints or more information: Select Care Dental 541-923-7633

We are committed to earning and maintaining your trust by protecting your health information with care and respect

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_