Patient Information

Name _____ Soc. Sec. # _____

Address_____ City _____ State _____ Zip _____

Phone _____ Cell _____ Email _____

Sex: M _____ F _____ Age _____ Birthdate: _____

Single / Married / Domestic Partner / Divorced / Widowed

Employer _____ Occupation _____ Business Phone _____

How do you prefer to be contacted? Phone / Text / Email

How did you hear about us? _____

Notify in case of emergency _____ Phone _____

Insurance Information

Do you carry dental insurance? No____Yes____ IF YES; PLEASE FILL OUT BELOW

Primary Insurance_____

Group#_____

Employer_____

Insured (Name)_____

Social Security #_____

Birthdate_____

Secondary Insurance_____

Group#_____

Employer_____

Insured (Name)_____

Social Security #_____

Birthdate_____

Authorization

Financial Policy

We are proud that our fees reflect the excellent service and care we provide. Dental treatment is an excellent investment in an individual's medical & psychological well-being. The following is a statement of our financial policy. Financial considerations should not be an obstacle to obtaining this important health service. Therefore, we provide the following payment options:

In-Office Payment: Patient portion of treatment (after the estimated insurance benefit) due when treatment begins. *We accept cash and checks, as well as Visa, MasterCard, American Express and Discover.

Care Credit: Payment plans ranging from 3 to 60 months. An 18% per year (1.5% per mo.) finance charge is applied to all balances unpaid after 90 days. All returned checks are subject to an additional collection fee.

Appointment Cancellation Policy

We realize that emergencies come up, however if you need to cancel for any reason, we request that every attempt is made to give us 48 hours notice. If you do not contact our office 24 hours prior to your appointment time there will be a $50.00 fee.Thank you in advance for your consideration regarding this matter.

Insurance

We are happy to process most insurance claims as a service to you at no charge. Through insurance verification, we can obtain a breakdown of your plan benefits and determine an estimated percentage of the total fee to be paid at your first visit. (This is your estimated co-payment.) Our fees are not related to your coverage. You and your employer purchase your coverage. Please realize that professional health care is rendered to you, the patient, not an insurance company. Even though we accept assignment of benefits that allows your insurance company to pay us directly, you are responsible for any amount not paid by your plan.

Thank you for reviewing and understanding our policies. Please let us know if you have any questions.

I have read, understand and agree to the above financial policy and appointment cancellation policy. I authorize my insurance company to pay my dental benefits directly to Cascade Dental Care. The undersigned acknowledges that our Notice of Privacy Practices has been made available.

Signature:_____

Date:_____

Dental History

What is your main concern today? _____

Are you experiencing any dental discomfort? _____

Former Dentist_____ Address_____ Phone _____

Date of last dental care_____ Date of last x-rays_____

Check (☑) if you have had any problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding/tender gums
- ☐ Periodontal treatment history
- ☐ Clicking, popping or jaw pain
- ☐ Grinding or clenching teeth
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to hot, cold, sweets, biting pressure
- ☐ Sinus problems
- ☐ Sores or growths in mouth or lips
- ☐ Do you wear a night guard applicance? Y / N

How do you feel about the appearance of your teeth?_____

Medical History

Physician's name_____ Phone_____ Date of last visit_____

Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or **dental** procedure? ☐ Y ☐ N

If yes, describe _____

Have you taken cocaine, methamphetamine, or any other recreational drugs in the last 24 hours?

☐ Y ☐ N *(Cocaine and anesthetic combined can be fatal)*

Are you currently under a physicians care? ☐ Y ☐ N If yes, describe _____

Women: Are you pregnant? ☐ Y ☐ N

Check (☑) if you have had any of the following:

- ☐ Allergies to medicine or food
- ☐ Material allergies (Latex, metal, chemicals)
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial joints (Hip, Knee, Shoulder)
- ☐ Asthma / Emphysema
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy / Radiation
- ☐ Diabetes
- ☐ Epilepsy / Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart problems
  - ☐ Mitral valve damage or prolapse
  - ☐ Pacemaker
  - ☐ Shortness of breath
  - ☐ Rheumatic/Scarlet Fever
  - ☐ High cholesterol
  - ☐ Circulatory problems
  - ☐ Other_____
- ☐ Hemophilia / Prolonged bleeding
- ☐ Herpes / HPV / Venereal disease
- ☐ Hepatitis A, B, or C
- ☐ HIV / AIDS Positive
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Kidney / Liver disease
- ☐ Psychiatric care
- ☐ Respiratory disease or shortness of breath
- ☐ Shingles
- ☐ Stomach problems
- ☐ Thyroid disease/ malfunction
- ☐ Tobacco habit
- ☐ Tuberculosis
- ☐ Recent International Travel
- ☐ Other _____

List medications you are currently taking, if any:

_____

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_____

List drug allergies, if any:

_____

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