CASCADE DENTAL CARE

Dental Patient Information Form

Patient Name: _____ Date: _____/_____/_____

Preferred Name (if different): _____

DOB: _____/_____/_____ Soc. Sec. # _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Email Address: _____

Employer: _____ Employer's Number: _____

Notify in Case of Emergency: _____ Phone Number: _____

Please mark the following criteria that applies to you:

( ) Man ( ) Woman ( ) Other

Please describe if your perceived identification is different:

_____

( ) Single ( ) Married ( ) Domestic Partner ( ) Divorced ( ) Widowed

Spouse or Domestic Partner's Name: _____ DOB: _____/_____/_____

Insurance Information

Do you carry dental insurance? ( ) NO ( ) YES IF YES; PLEASE FILL OUT BELOW

Primary Insurance: _____ Secondary Insurance: _____

ID Number: _____ ID Number: _____

Group#: _____ Group#: _____

Employer: _____ Employer: _____

Insured (Name): _____ Insured (Name): _____

Social Security #: _____ Social Security #: _____

DOB: _____/_____/_____ DOB: _____/_____/_____

CASCADE DENTAL CARE

Dental Patient Medical Form

Patient Name: _____ DOB: _____/_____/_____

Please answer these questions as best you can. We want to know your special needs so we can give you the best care. Please circle the answer that is right for you, "Yes" or "No".

Medical

Are you under the care of a physician or receiving any ongoing medical care? Yes or No

Name of your physician: _____

Physician's phone Number: _____

Do you have any artificial joints, heart valves, implants, or prosthesis? Yes or No

If yea, please explain: _____

Have you ever been told you need to pre-medicate prior to dental treatment? Yes or No

If yes, please explain: _____

Have you taken cocaine, methamphetamine, or any recreational drugs in the last 24 hours? Yes or No

Are you pregnant or breastfeeding? Yes or No

If yes, due date: _____

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

( ) Allergies to medicine or food
( ) Material allergies
( ) Anemia
( ) Asthma
( ) Back problems
( ) Blood disease
( ) Cancer
( ) Chemical dependency
( ) Chemotherapy/ Radiation
( ) Diabetes
( ) Epilepsy
( ) Glaucoma
( ) Low blood pressure
( ) Heart Problems
( ) Mitral valve damage/ Prolapse
( ) Pacemaker
( ) Fainting
( ) Rheumatic/ Scarlet Fever
( ) High Cholesterol
( ) Circulatory problems
( ) Hemophilia/ Prolonged bleeding
( ) Herpes/ HPV/ Venereal disease
( ) HIV/ Aids positive
( ) High blood pressure
( ) Emphysema
( ) Kidney/ Liver disease
( ) Psychiatric care
( ) Respiratory disease
( ) Shingles
( ) Stomach problems
( ) Thyroid disease
( ) Tobacco habit
( ) Tuberculosis
( ) Recent international travel
( ) Other_____

_____

If answered yes to any of the above, please explain:

_____

_____

CASCADE DENTAL CARE

Dental Patient Dental Form

Please answer these questions as best you can. We want to know your special needs so we can give you the best care. Please circle the answer that is right for you, "Yes" or "No".

Dental

Are you having any dental discomfort at this time? Yes or No

If yes, please explain: _____

Have you ever had any abnormal bleeding associated with previous extractions, Yes or No

Surgery, or trauma?

If yes, please explain: _____

Former Dentist: _____ Phone Number: _____

Date of your last dental visit: _____ Date of last x-rays: _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

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

( ) Bad breath	**( ) Grinding or clenching teeth**	**( ) Sinus problems**
( ) Bleeding/ Tender gums	**( ) Food collection between teeth**	**( ) Sores/ Growths in mouth or lips**
( ) Periodontal treatment history	**( ) Loose teeth or broken fillings**	**( ) Use a night guard appliance**
( ) Clicking, popping, or jaw pain	**( ) Sensitivity to hot, cold, sweets, biting pressure**	

List medications you are currently taking, if any:

_____

_____

_____

_____

List all allergies, if any:

_____

_____

_____

_____

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. I herby give my consent to treatment for myself, or the named patient (of who I am the parent, legal guardian, or foster parent) to Cascade Dental Care.

Signature of Patient or Guardian: _____

Date: _____/_____/_____

Financial Disclaimer

Patient Name:_____ **DOB:**____/____/____

Please read carefully and sign to acknowledge understanding and agreement.

Thank you for choosing us as your dental care provider. We are committed to providing you with the best dental care available.

Available Payment Options.

You can choose from ~ **Cash, Check, Visa, Mastercard, American Express**

CareCredit payment plan option, ask us for detailed information.

Regarding Insurance.

- **For covered services, we ask that all co-pays and deductibles be paid on the day of treatment.** Since your insurance company may not cover all costs, we ask that you pay any percentage of your balance not paid by your insurance on the day of treatment.
- **For services that are not covered by your insurance, we ask that you pay the entire fee the day of your treatment.**

- We will attempt to answer any questions we can about your insurance and we will assist in resolving complications with your insurance company. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer, and your insurance carrier. In the event that your insurance company has not paid (on your behalf), you will be responsible to pay the remaining balance.

Patients Without Insurance.

For those patients without insurance coverage, you will be responsible for payment on the day of treatment.

- If you are not able to pay in full, or if your treatment requires several visits, you will be given an estimate and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy.

- Our office requires notice to cancel your appointment in the case of an emergency.
  We reserve the right to charge a fee, for those not giving notice at least 24 hours prior to your scheduled appointment.

Collections

You are responsible to pay all costs of collecting, or attempting to collect any debt owed on this account. This includes all attorney's fees, interest and late fees.

Patient Signature: _____ **Date**: _____

CANCELLATION POLICY

Cascade Dental Care is committed to giving all our patients the very best care. Unfortunately, when an appointment time is reserved and not cancelled appropriately, it cannot be utilized by another patient in need.

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 **24-48 hours' notice**. If you do not contact our office at least 24 hours prior to your appointment time, there will be a charge.

Our **missed appointment fee is $50.00**, thank you in advance for your consideration regarding this matter.

Patient Signature: _____

Date: _____/_____/_____

HIPAA Information and Consent Form

The health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of the business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Cascade Dental Care may disclose my dental/ billing information to the following recipients:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

I _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____

Date: _____/_____/_____