Patient/Guardian Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form helps us provide the absolute best care for you.

Patient Name:		Date of Birth:	Sex:	Age: Gua	ardian Name:				
Home Address:		(City:		State:	Zip:			
Billing Address (if different):			City:		State:	Zip:			
Home Phone:	Cell:	Email:		Drive	er's License# and	State			
SS#:	Em	ployer/Occupation:			Business Ph	one:			
Spouse's Name and P	hone #:	E	Emergency Phone # (other than spouse):						
Primary Dental Insura		Group #:							
Secondary Dental Ins	(Group#:							
Subscribers Name:			Date of Birth: SS #:						
Name of Previous De	ntist:	[Date of last Visit to Dentist:						
Referred to us by:		H	Hobbies:						
said professional servinsurance payment.	cade Smiles for the dotherwise paya exceed my indeby pay in a current notice charges over a	e dental expense ble to me. tedness to Cascade nanner, any balance of and above this	If it becomes necessary to effect collection of any am owed on this or subsequent visits the undersigned as pay for all costs and expenses, including reasonable afees. I hereby authorize the doctor to release inform necessary to secure payment of benefits. Billing charge is 1.5% per month – annual percentage 18% - on balances over 90 days. Minimum billing charge of Parent/Patient:						
Patient Ackr	nowledgement of	Receipt of Notice of Pri	vacy Practices a	and Consent A	uthorization and	Release Form			
Date:		of a copy of the current							
copy of this signed, d	ated document sh	hall be as effective as the phs be sent to other atte	original. My si	gnature will a	lso serve as a PHI	•			
Please <u>print</u> your nan	ne:	Please <u>sig</u>	<u>n</u> your name:						
If completing for som	eone else: Leg	al Representative:		Des	cription of Autho	rity:			
How do you want to l	oe addressed whe	n summoned from the r	eception area:	□ First Name	□ Proper Surnan	ne 🗆 Other			
•		ave access to your health		nship:					
I authorize contact from the second s	-	onfirm my appointment	ts, treatment &	billing inform	nation and to have	e <u>information about</u>			
□ Cell Phone □ H	ome Phone □ V	Vork Phone □ Email □	☐ Any of the Ab	ove					

Welcome to Cascade Smiles

Last First Initial Nickname Age	Pat	ient's Name							
DENTAL HISTORY - CHECK THE APPROPRIATE BOX What is your chief concern today? 1. What is your chief of sires visit to a dentist?				First	Initial	Nickname	Age		-
DENTAL HISTORY - CHECK THE APPROPRIATE BOX What is your chief concern today? 1. What is your chief of sirely since the last visit to a dentist? If not, how long since the last visit to the dentist? Were any x-rays or radiographs taken when your child previously visited the dentist? Were any x-rays or radiographs taken when your child previously visited the dentist? Does your child cat between meals? Does your child eat betweets such as candy, soda pop, chewing gum? 4. When does your child brush his/her teeth? Upon arising Alfer cating any food Right after meals Before going to bed	Par	ent's Guardian's Nar	ne						
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If not, how long since the last visit to the dentist?	2.	Is this your child's t	first visit to a dentist?						
Does your child eat between meals?		If not, how long sin	ce the last visit to the	dentist?					
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CHILD DENTAL / MEDICAL HISTORY

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