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: Guardian Name:

Home Address: City: State: Zip:

Billing Address (if different): City: State: Zip:

Home Phone: Cell: Email: Driver's License# and State

SS#: Employer/Occupation: Business Phone:

Spouse's Name and Phone #: Emergency Phone # (other than spouse):

Primary Dental Insurance: Group #:

Secondary Dental Insurance: Group#:

Subscribers Name: Date of Birth: SS #:

Name of Previous Dentist: Date of last Visit to Dentist:

Referred to us by: Hobbies:

Insurance Assignment of Benefits Record Release Authorization/Financial Responsibility

I, , hereby instruct and direct my dental insurance company, , to pay directly to Cascade Smiles for the dental expense benefits allowable and otherwise payable to me.

This payment will not exceed my indebtedness to Cascade Smiles and I agree to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collection of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

Billing charge is 1.5% per month – annual percentage rate of 18% - on balances over 90 days. Minimum billing charge is $2.

Signature of Policyholder:_____ Signature of Parent/Patient:_____ Date:_____

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent Authorization and Release Form

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process your insurance claims.

Date:

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.

Please **print** your name: Please **sign** your name:_____

If completing for someone else: Legal Representative: Description of Authority:

How do you want to be addressed when summoned from the reception area: ☐ First Name ☐ Proper Surname ☐ Other

Please list any other parties who can have access to your health information:
Names: Relationship:

I authorize contact from this office to **confirm my appointments, treatment & billing information** and to have **information about my health** conveyed via:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ **Any of the Above**

Welcome to Cascade Smiles

Patient's Name _____ _____ _____ _____ _____
Last First Initial Nickname Age

Parent's Guardian's Name _____

DENTAL HISTORY - CHECK THE APPROPRIATE BOX	**YES**	**NO**
1. What is your chief concern today? _____		
2. Is this your child's first 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? ..	☐	☐
3. Does your child eat between meals? …….	☐	☐
Does your child eat sweets, such as candy, soda pop, chewing gum? …….....	☐	☐
4. When does your child brush his/her teeth?		
☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed		
5. How does your child receive Fluoride?		
☐ Community water level ____ ppm ☐ Well water level ____ ppm		
☐ Fluoride drops or tablets ☐ Fluoride rinse or gel		
6. Have any cavities been noted in the past? ……	☐	☐
7. Were any teeth (baby or permanent) removed by extraction? …….	☐	☐
Was it suggested that the space be maintained? ……..	☐	☐
Was an appliance placed? ……	☐	☐
8. Have there been any injuries to teeth, such as falls, blows, chips, etc? ……...	☐	☐
If so, describe _____		
9. Has your child had any problem with dental treatment in the past? ……	☐	☐
10. Has anyone in the family, including parents, had orthodontics? …….	☐	☐
11. Has your child ever received a local anesthetic? ……..	☐	☐
12. Has your child ever had occlusal sealants? ……..	☐	☐
13. Does your child think there is anything wrong with his/her teeth? ……..	☐	☐
MEDICAL HISTORY		
1. Does your child have a health problem? ……..	☐	☐
2. Is your child under care of physician? …….	☐	☐
If yes, since when and why? _____		
Name of physician _____ Phone _____		
3. Is your child receiving any medication? ……...	☐	☐
What? _____		
4. Is your child allergic to penicillin, antibiotics or other drugs? …….	☐	☐
5. Is your child allergic to or sensitive to any metals or latex? ……	☐	☐
6. Does your child have other allergies? ……..	☐	☐
7. Has your child had any serious illness? ……...	☐	☐
When _____ What _____		
8. Has your child ever had surgery? ……	☐	☐
9. Does your child have a heart murmur? …….	☐	☐
10. Does your child experience severe or prolonged bleeding? …….	☐	☐
11. Does your child have AIDS or has he/she tested HIV positive? ……..	☐	☐
12. Has your child tested positive for hepatitis? …….	☐	☐
13. Is your child subject to nervous disorders? ……..	☐	☐
☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?		
14. Does your child have frequent headaches? ……..	☐	☐

15. Has your child had history of: (Check Responses) ☐ diabetes, ☐ heart trouble, ☐ asthma
☐ rheumatic fever, ☐ epilepsy, ☐ cerebral palsy, ☐ liver problems, ☐ congenital birth defects,
☐ mental disability, ☐ eyesight problems, ☐ cancer, ☐ infections, ☐ speech impairments

16. Describe any other medical concern _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

CHILD DENTAL / MEDICAL HISTORY

Med. Alert