



Patient Information

Who can we thank for referring you to our office? _____

Patient Name: _____ Date of birth: _____ Sex: _____ Married Single

If under 18, Guardian Name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip _____

Home #: _____ Cell #: _____ Work #: _____

Driver's license #: _____ State Issued: _____ Email: _____

SS#: _____ Employer: _____ City: _____

In case of an emergency, who would you like us to contact: _____ **ph#** _____

Dental Insurance

As a courtesy we will bill your dental insurance for services rendered. Your patient portion is due at the time of service. We will do our best to estimate your patient portion, any treatment plan is just an estimate and you are ultimately responsible for all services rendered.

Subscriber Name: _____ SS or ID# _____ DOB _____

Primary Dental Insurance: _____ Group # _____ Employer _____

Subscriber Name: _____ SS or ID# _____ DOB _____

Secondary Dental Insurance: _____ Group # _____ Employer _____

Our Office Policies

Our office is committed to providing you with the finest quality dental care. In order to achieve this goal, we need your cooperation and your understanding of our appointment and payment policies.

Appointment Policy

Your appointment time is reserved especially for you. We respect your business schedule and make every effort to see you at your scheduled time. Please help us achieve this goal by being punctual for your appointment. In the event you are unable to keep your appointment, we respectfully request a minimum of 48 hours notice.

A missed appointment fee of \$125.00 may be charged.

Thank you in advance for your cooperation.

For our patients without dental benefits:

Your payment is expected at the time services are rendered. **We accept: CASH, VISA, MASTERCARD, AMEX, and CARE CREDIT.**

For our patients with dental benefits:

As a courtesy to you, we will gladly submit your insurance claim on your behalf. However, we require payment of your estimated co-pay at the time of each visit. Please be advised that your dental insurance is a contract between you and your insurance company and that patient charges are a contract between you and our office. Therefore, you are ultimately responsible for any balance on your account.

Authorization and release

Please be advised that the person signing this form is ultimately responsible for all account transactions and balances. Interest will accrue at the rate of 5% per month on all outstanding balances.

If insurance is involved: I authorize payment directly to Cascadia Dental Specialists of group benefits otherwise payable to me.

Thank you for taking the time to completely read and sign this form

Print Name _____

Signature _____ Date _____

Medical Health History		
Name:	Date:	SS#:

Please check box if you have any of the following: (please read carefully)

<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Frequent nosebleeds	<input type="checkbox"/> kidney disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Anemia	<input type="checkbox"/> Lung disease or TB	<input type="checkbox"/> Back or Neck Pain
<input type="checkbox"/> Mitral Valve Prolapsed	<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Herpes or other STD
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke (s)	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Artificial Heart valve	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hay fever/skin rashes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis/ liver disease
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Smoker/ <input type="checkbox"/> chew tobacco	<input type="checkbox"/> HIV/AIDS

NONE OF THE ABOVE

Please provide explanation if you check marked any of the above listing or if you have any disease, condition, or problem not listed:

Please provide explanation next to the question that applies to you:

Have you had major operation/hospitalization?	Yes/No
Do you have joint replacement less than 2 years?	Yes/No
Do you have joint replacement more than 2 years?	Yes/No
Have you had blood transfusion?	Yes/No
Have you ever taken Phen-fen?	Yes/No
Have you ever taken Fosamax / Bisphosphonate?	Yes/No
Psychiatric treatment?	Yes/No
Do you have a Jaw Pain or TMJ disorder (TMD)?	Yes/No
Do you clench or grind your teeth?	Yes/No

Do you take any of the following medications?

<input type="checkbox"/> Antibiotic s (for what reason?)	<input type="checkbox"/> Blood pressure medicine	<input type="checkbox"/> Heart medicines e.g. Digitalis
<input type="checkbox"/> Anticoagulants e.g., Coumadin	<input type="checkbox"/> Insulin, Orinase, or similar	<input type="checkbox"/> Nitroglycerin
<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Cortisone (steroids)

Please list any medication you are taking including prescriptions drugs, non-prescriptions and supplements?

****Have you been advised to premedicate before dental treatments? YES / NO**

Are you Allergic to any of the following? Please circle one

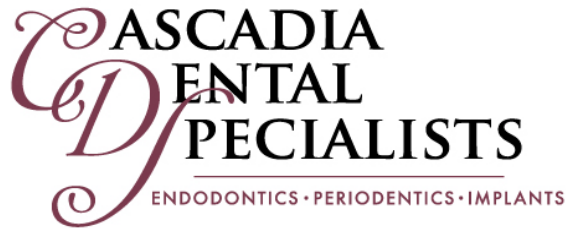
Novocaine or local anesthetics YES/NO	Aspirin, Acetaminophen, Ibupr. YES/NO	House hold bleach YES/NO
Penicillin YES/NO	Codeine, Demerol, or narcotics YES/NO	Metals YES/NO
Sedative or Barbiturates YES/NO	Latex YES/NO	sulfa drugs YES/NO

Other Allergies, please explain:

Women: Pregnant Yes/No	Nursing Yes/No	Contraceptives Yes/No	Reached Menopause Yes/No <input type="checkbox"/> NONE
-------------------------------	----------------	-----------------------	--

Is there any other information you would like us to know? _____

Patient/Parent Signature: _____ Date: _____



Oral Cancer Screening

One person every hour dies of oral cancer in America; however, when detected early enough, the survival rate for oral cancer is very high.

Studies have shown; if found early enough oral cancer's five year survival rate is 90% and if found late the survival rate is only about 30%.

VELescope technology is the first cleared by both the FDA and health Canada to help clinicians discover cancerous and precancerous lesions that might not be apparent to the naked eye.

We at Cascadia Dental Specialists are celebrating the detection of oral cancer. All of our patients will receive \$10 off from a total \$40 value which is \$30 for the entire year or \$20 for today's visit.

- I accept the whole year option @ \$30.00
- I accept to pay only for this appointment @ \$20.00
- I decline both options

Patient Name: _____

Patient Signature: _____ Date: _____



Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the offices of Cascadia Dental Specialists, Inc. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Cascadia Dental Specialists, Inc. reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons below:

- ANY MEMBER OF MY IMMEDIATE FAMILY
- SPOUSE ONLY
- OTHER(please specify)_____

Patient Name: _____

Signature of Patient: _____
(or personal representative's authority)

Date: _____