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 from 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_________________

CASCADIA DENTAL SPECIALISTS
ENDODONTICS · PERIODONTICS · IMPLANTS

Medical Health History		
Name:	Date:	SS#:

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

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

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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?

[]Antibiotic s (for what reason?)	[] Blood pressure medicine	[] Heart medicines e.g. Digitalis
[] Anticoagulants e.g., Coumadin	[] Insulin, Orinase, or similar	[] Nitroglycerin
[]Tranquilizers	[] Aspirin	[] Cortisone (steroids)

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

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****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 [] 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:__________________

Jamshid Faghih, DDS, MDS Endodontics ● **Huda Albather, DDS, MDS, MPH** Periodontics & Implants
14700 NE 8th St, Suite 205 ● Bellevue, WA 98007 ● P 425.644.7444 F 425.649.8884 ● www.cascadiadental.com

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 migh 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 disclsure 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:________________________