CASCADE FAMILY DENTAL

Thank you for selecting us to provide for your oral health needs. We promise our best in providing you with Excellence, Value, and Care in dentistry. We hope to be an office that you love and would refer your family and friends to. Please let us know if there is anything we can to improve your experience.

Referral Information *(What brought you to visit us?)*

☐ Referral *(who?)*_____ ☐ Location _____

☐ Advertisement *(which one?)* _____ ☐ Other *(please describe?)* _____

Patient Information

Full Name:_____ Preferred Name: _____

Birth date:_____ SS#:_____

☐ Married, ☐ Single, ☐ Child, ☐ Widowed, ☐ Divorced

Household/ Guardian*(You only need to complete this section once per family. All fields are required)*

Name:_____ Relationship: _____

Home Address: _____

City:_____ State:_____ Zip code: _____

Home Phone: _____Wireless Phone:_____ Work Phone: _____

Cell Phone Carrier *(only needed if you want text message appt. reminders):* _____

Family Email (appt. reminders only): _____

Emergency Contact: _____ Relationship:_____ Phone:_____

Insurance Information *(Make sure we make a copy of your primary and **secondary insurance cards**)*

Subscriber's Name: _____

SS#:_____ Subscriber's Birthday: _____

Employer: _____

Our Commitment to Each Other

Warranty

We guarantee all of our work and will replace anything resulting from technique or material error at no cost to you if you maintain regular 6 month maintenance visits and complete all necessary work. Not doing these things will jeopardize the success of the work we perform. We offer this because we use the best materials and techniques available.

Privacy Policy

We are committed to keeping all of your information private and will not discuss or share personal information except with those authorized by you. Your email is kept private. We fully comply with all provisions of HIPAA *(Health Insurance Portability and Accountability Act of 1996)*.

Consent to Procedures

You authorize the doctors and/or the staff at Cascade Family Dental to perform those procedures agreed upon and within the standard of care on you (or at your request, to your minor child or ward). We commit to informing you about all procedures. We encourage you to diligently ask us if you have any questions about any procedures or their necessity, for we want you completely comfortable through the entire process.

Payment Policy

- You agree to be responsible for your own dental bill and to keep us updated of your current insurance information.
- We will bill your insurance as a courtesy; however, you are ultimately responsible for all services performed and charges received whether covered or not.
- All copayments are due at time of service.
- We accept cash, credit cards, and checks. We offer **4 and 12 month payment plans, some at 0% interest OAC**.
- We charge $40 for all missed appointments w/o 48 hr notice or if appointment canceled because of inability to pay at time of service.
- You agree to pay any late fees and interest charges assessed if your account becomes past due. If your account must be turned over to collections, you agree to pay a 40% collection fee on any unpaid balance in accordance with Utah Code Annotated, sec 12-1-11.

Signature:_____ Date:_____ Relationship to Patient: _____

Health History

Yes No

☐ ☐ 1. Have you been under a physicians care or had any health problems in recent years?

If yes, explain _____

_____

Physicians name:_____ Phone: _____

☐ ☐ 2. Please list name and purpose of any medications you currently take _____

_____

_____

☐ ☐ 3. Have any allergies? ☐ Latex, ☐ Antibiotics, ☐ Metal, ☐ Local Anesthetic, ☐ Other *(explain)* _____

☐ ☐ 4. *(Women)* Are you pregnant or trying to get pregnant?

☐ ☐ 5. Do you have any pain now?_____

☐ ☐ 6. Does the dental treatment make you nervous?

☐ ☐ 7. Are you interested in cosmetic procedures (bleaching, veneers) ?

☐ ☐ 8. Are you interested in braces or Invisalign (adults and youth)?

☐ ☐ 9. Do you have a history of gum disease? _____

☐ ☐ 10.Do you want missing teeth replaced? _____

11. When was your last dental visit? _____

12. Other information the dentist should know _____

Do you have or have you had any of the following?

Yes	No		Yes	No	
☐	☐	Heart problems _____	☐	☐	Asthma *(last attack?)*_____
☐	☐	Blood disorders _____	☐	☐	Diabetes *(type?)* _____
☐	☐	High Blood Pressure	☐	☐	Tuberculosis *(when?)* _____
☐	☐	Angina/Chest Pain	☐	☐	Kidney Disease
☐	☐	Heart Attack *(when?)* _____	☐	☐	Fainting or Seizures
☐	☐	Stroke *(when?)* _____	☐	☐	Tobacco products _____
☐	☐	Require antibiotic premedication	☐	☐	Alcohol *(how often?)*_____
☐	☐	Rheumatic Fever	☐	☐	Recreational drugs (i.e. narcotics)
☐	☐	Prosthetic heart valves	☐	☐	Take Medications for Osteoporosis
☐	☐	Pacemaker	☐	☐	Click in jaw/TMJ/Neck pain
☐	☐	Artificial joints *(when?)* _____	☐	☐	Migraine/ Headaches
☐	☐	Bruise easily	☐	☐	Snoring or Sleep Apnea
☐	☐	Hepatitis or liver disease Type?_____	☐	☐	Cold sores/ Mouth Ulcers
			☐	☐	Dry Mouth, typical w/ medications
☐	☐	HIV or AIDS	☐	☐	Regular Sinus Problems
☐	☐	Cancer *(type?)* _____	☐	☐	Other _____

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical conditions or medications can affect dental treatment, I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature_____ Date _____

(Patient, legal guardian or authorized agent of patient)