CASEY DENTAL

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Patient Information (confidential)

Name: _____ **DOB:**_____ **Soc. Sec. #**_____
Address:_____
City: _____**State:** _____**Zip:**_____
Cell Phone :(_____)_____ Home:(___)_____Work:(___)_____
E-Mail: _____ Gender: ☐ M ☐ F
Patient Occupation:_____ Patient Employer:_____

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed
If married, spouse name _____
☐ **Minor(please add parent info below if under 21years old)**

21 AND UNDER—PLEASE ADD PARENT INFORMATION

Marital Status of parents:
Single Married Divorced Partnered Separated Widowed

Mother's Information
Parent Legal Guardian Step Mother
Name: _____
Email: _____
Mother's DOB:_____/_____/_____
SS#:_____ DL:_____
Home Tel #:_____
Work Tel#:_____
Cell #:_____
Employer: _____

Father's Information
Parent Legal Guardian Step Father
Name: _____
Email: _____
Father's DOB:_____/_____/_____
SS#:_____ DL:_____
Home Tel #:_____
Work Tel#:_____
Cell #:_____
Employer: _____

Whom May We Thank for Referring You?(Select one or more)

☐ Internet ☐ Location ☐ Newspaper ☐ TV/Radio ☐ Patient / Friend
Name of Patient: _____

Emergency Contact (Specify someone who does not live in your household):

Name: _____Relationship: _____
Address: _____
Cell phone :(____) _____ Home Phone :(_____) _____

Who is responsible for this account? _____
Relationship to patient: _____

Insurance Information

Primary Insurance:

Name of Insured: _____
Relationship to patient: _____
Policy Owner's DOB: _____/_____/_____
ID #: _____
Insurance Co. Name: _____
Insurance Co Phone #: _____
Group # (Plan, Local, or Policy #): _____

(Secondary) Insurance (if Applicable):

Name of Insured: _____
Relationship to patient: _____
Policy Owner's DOB: _____/_____/_____
ID #:_____
Insurance Co. Name: _____
Insurance Co Phone #: _____
Group # (Plan, Local, or Policy #):_____

Dental History

Have you ever had an unpleasant dental experience? □ yes □ no
If yes, please explain: _____
_____
Reason for today's visit:
_____
Date of last dental visit:_____
Were X-rays taken? □ yes □ no
If yes, did you bring the X-rays with you?
□ yes □ no

Do you like the color of your teeth?
□ yes □ no

Do you like your smile? □ yes □ no
If no, please explain:_____
_____

How often do you brush?_____

How often do you floss?_____

Please mark "yes" or "no":

Bad breath	□ yes	□ no	Jaw pain or tiredness	□ yes	□ no
Bleeding gums	□ yes	□ no	Lip or cheek biting	□ yes	□ no
Blisters on lips or mouth	□ yes	□ no	Loose teeth or broken fillings	□ yes	□ no
Burning sensation on tongue	□ yes	□ no	Mouth breathing	□ yes	□ no
Chew on one side of mouth	□ yes	□ no	Mouth pain, brushing	□ yes	□ no
Cigarette, pipe, cigar smoking	□ yes	□ no	Orthodontic treatment	□ yes	□ no
Clicking or popping jaw	□ yes	□ no	Pain around ear	□ yes	□ no
Dry Mouth	□ yes	□ no	Periodontal treatment	□ yes	□ no
Fingernail biting	□ yes	□ no	Sensitivity to cold	□ yes	□ no
Food collection between teeth	□ yes	□ no	Sensitivity to heat	□ yes	□ no
Foreign objects	□ yes	□ no	Sensitivity to sweets	□ yes	□ no
Grinding teeth	□ yes	□ no	Sensitivity when biting	□ yes	□ no
Gums swollen to tender	□ yes	□ no	Sores or growths in mouth	□ yes	□ no

Which of the following would **KEEP YOU FROM** having dental treatment?
□ Fear of Pain □ Lack of Concern □ Cost of Treatment □ Missing Work Time

Medical History

Height_____ Weight_____

Physician's Name _____ **Date of last visit** _____
Physician's Phone Number: (____)_____

Have you or are you taking any of the following medications (Bis-Phosonates): Aredia Zometa Fosamax Actonel or Boniva? □ **yes** □ **no**

Have you or are you taking any of the following medications (SSRI's): Lexapro Prozac Paxil Zoloft Luvox Effexor? □ **yes** □ **no**

Medications: • **None**
List any medications you are currently taking and the correlating diagnosis:_____
_____
_____

(Women only) Are you or could you be pregnant? □ No □ Yes
If yes, approximately how many weeks?_____

Have you been seriously ill or hospitalized in the last 5 years? □No □ Yes
(If yes please explain)_____

Do you snore? • **Yes** • **No**
Do you often feel excessively tired during the day? • **Yes** • **No**

Allergies (or Sensitivies) ☐ **None**		
☐ Aspirin	☐ Local Anesthetic	☐ Iodine
☐ Barbiturates	☐ Penicillin/Other Antibiotics	☐ Latex
☐ Seasonal	☐ Sleeping Pills	☐ Codeine/Other Narcotics
☐ Sulfa Drugs	☐ Other:_____	

Have you ever been diagnosed with sleep apnea? • No • Yes
If yes, what type of machine do you use? _____

Please mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	□ yes	□ no	Epilepsy	□ yes	□ no	Radiation Treatment	□ yes	□ no
Anemia	□ yes	□ no	Glaucoma	□ yes	□ no	Fainting or dizziness	□ yes	□ no
Headache	□ yes	□ no	Rheumatic Fever	□ yes	□ no	Arthritis, Rheumatism	□ yes	□ no
Asthma	□ yes	□ no	Scarlet Fever	□ yes	□ no	Respiratory Disease	□ yes	□ no
Herpes	□ yes	□ no	Artificial Joints	□ yes	□ no	Artificial Heart Valves	□ yes	□ no
Stroke	□ yes	□ no	Heart Murmur	□ yes	□ no	Shortness of Breath	□ yes	□ no
Cancer	□ yes	□ no	Heart Problems	□ yes	□ no	Bleeding Abnormally	□ yes	□ no
Jaw Pain	□ yes	□ no	Sinus Trouble	□ yes	□ no	with extractions or surgery		
Skin Rash	□ yes	□ no	Back Problems	□ yes	□ no	High Blood Pressure	□ yes	□ no
Special Diet	□ yes	□ no	Blood Disease	□ yes	□ no	Swollen Feet or Ankles	□ yes	□ no
Jaundice	□ yes	□ no	Hepatitis Type	□ yes	□ no	Swollen Neck Glands	□ yes	□ no
Ulcer	□ yes	□ no	Kidney Disease	□ yes	□ no	Tumor / Growth on head/neck	□ yes	□ no
Diabetes	□ yes	□ no	Thyroid Problems	□ yes	□ no	Chemical Dependency	□ yes	□ no
Pacemaker	□ yes	□ no	Low Blood Pressure	□ yes	□ no	Congenital Heart Lesions	□ yes	□ no
Chemotherapy	□ yes	□ no	Circulatory Problems	□ yes	□ no	Mitral Valve Prolapse	□ yes	□ no
Liver Disease	□ yes	□ no	Venereal Disease	□ yes	□ no	Cough, persistent or bloody	□ yes	□ no
Emphysema	□ yes	□ no	Nervous Problems	□ yes	□ no	Cortisone Treatments	□ yes	□ no
Psychiatric Care	□ yes	□ no	Auto Immune Disorder	□ yes	□ no	Acid Reflux	□ yes	□ no

If you have any questions or concerns about your treatment or procedure please feel free to ask!

It is important we have your medical and dental history, this information is kept strictly confidential in accordance with HIPPA guidelines. Thank You.

Patient's Signature: _____ **Date:** _____
(Parent's Signature if patient is under 18)

Hygienists/ Assistant Signature: _____ ***Date:*** _____

Doctors Signature: _____ ***Date*****:** _____

Doctor's Comments: _____

_____

_____

_____

CASEY DENTAL

Office Policies

Below is a list of our office polices so that we can inform you ahead of time of important information pertaining to your continuing care at Casey Dental. Along with this brief outline, a pamphlet containing information will be given to you. If further information is desired, one of our staff members would be happy to assist you.

I. Confirming Appointments

Our office confirms your appointment by:

Cell Phone
Cellular Carrier: _____ Email: _____
Phone Call: _____ Home Phone: _____
Text Message: _____

If you have to cancel your appointment, we request a **24 hour courtesy call.** Multiple cancellations and "no show" visits may result in termination from the practice and a $50.00 charge. A broken appointment is a loss to three people-- the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

_____**Initial**

II. Dental Insurance

Dental Insurance is a contract between your employer and a dental insurance company. The benefits you will receive are based on the terms of the contract that are negotiated between your employer and dental insurance company. You are responsible to know your dental benefits upon coming into our office. If you are unsure of your coverage, our staff would be happy to review it with you.

_____**Initial**

III. Payments

Payments, such as co-pays and deductibles, will be due the **day of service.** The estimated amount due is calculated and can be reviewed before your visit. A copy of your explanation of benefits will also be sent to you from your insurance carrier. At Casey Dental, we accept the following forms of payment: Via, MasterCard, Discover, Personal Check, Cash and payment plans such as Care Credit and Springstone.

_____**Initial**

I _____ (print name) acknowledge that I have read these policies and have received the Office Policy Information Pamphlet.

Signature: _____ Date: _____
Staff Member: _____ Date: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you disagree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____ day of _____, 20 _____.

Print Patient Name: _____

Relationship to Patient: _____

Treatment may be discussed with:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Signature: _____

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