Smile Assessment Form

Please consider each statement carefully and circle **YES** or **NO**. The doctor and members of the dental team will discuss your response with you in confidence.

1. I am concerned about the appearance of my teeth or my smile. YES NO
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth. YES NO
3. I am concerned about the position or angle of one or more of the teeth. YES NO
4. I am concerned about the shape of one or more of my teeth. YES NO
5. In social situations, I am sometimes embarrassed by my teeth or my smile. YES NO
6. There are some things about my upper front teeth that I would like to change. YES NO
7. There are some things about my lower front teeth that I would like to change. YES NO
8. I have old fillings/previous dental treatment that is no longer satisfactory to me. YES NO
9. I am missing one or more of my teeth. YES NO
10. I am interested in learning more about esthetic dentistry. YES NO
11. I am interested in learning more about sedation dentistry. YES NO
12. It has been more than 2 years since my last dental visit. YES NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____ Date: _____

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Cascades Center for Dental Health

Patient Information Form

Patient Name: _____ Date:_____
Last First MI
□Male □Female □Married □Single □Child □Other

Social Security #: _____ Birth Date: _____ E-Mail_____

Phone (Home): _____ Mobil/Cell: _____ Work: _____ Ext: _____Other_____

Address: _____
Street Apartment #
_____
City State Zip Code

In case of Emergency, contact: Name: _____Phone: _____ Relationship: _____

Health Information
Previous Dentist: _____

Date of Last Dental Visit: _____ Date of last x-rays:_____

Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excess Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis _
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mental Disorders
- ☐ MVP
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy: Due_____
- ☐ Prescribed Weight Loss Meds
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Usage
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other:_____ _____

Allergies:

- ☐ Antibiotic Allergy
- ☐ Adhesive Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Other Allergies_____ _____ _____

Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

Are you now under the care of a physician? □ Yes □ No Why? _____

Name of Physician: _____Phone_____

Do you have any health problems that need further clarification? □ Yes □ No _____

Are you taking any medications over the counter or prescribed? Please List: _____

What is your primary source of water? □ Well □ County ☐ Bottled

Do you pre-medicate for dental appointments? □ Yes □ No If so, why: _____

*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature_____ Date_____

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Insurance Information

Name of Primary Subscriber: _____ Birth Date: _____

ID#:_____ Group#:_____ Is the insured a patient? □ Yes □ No

Insurance Plan Name and Telephone: _____

Subscriber Address: _____
Street Address City State Zip

Subscriber Employer Name: _____

Patient's relationship to Subscriber: □ Self □ Spouse □ Child □ Other_____

Assignment of Benefits
I authorize the release of any dental information necessary to process claims and payment of dental benefits to the named provider for professional services rendered.

Name_____Date_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. Our practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies, and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of three (3) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content
_____ Date_____ Relationship to Patient_____
Signature of patient, parent, or guardian

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Office Dental Insurance Information and Financial Policies

Dear Patient,

Thank you for choosing our office for your dental needs! We would like to acquaint you with our policies regarding dental insurance, schedule changes, etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope you and your family will feel welcome in our practice and have the ultimate experience in dentistry each visit.

♦Dental Insurance-If you have dental insurance, as a service to you, we will submit all claims to the insurance company with all the necessary information and x-rays. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship. Therefore, the estimated patient portion is expected in-full at the time of service.
♦Monthly payments- If you need to make long-term payments, you may qualify for one of our long term payment options offered through one of our financial partnerships. Please see one of our team members for more details.
♦ Credits- It is the patient's responsibility alone to inquire about the possibility of a credit on his or her account. If the patient would like to receive a refund check, please contact our office and speak to a team member so that a request may be processed.

We reserve the right to charge for appointments broken or rescheduled without the proper 2 business day notification.

SIGNIFICANT EXPOSURE- Section 32.1-45,1(A) and (B), Code of Virginia (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and/or healthcare worker thereby granting the hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles, or non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest, and any other charges incurred to collect on my account.

_____ _____

Signature of patient or guardian Date

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Office Cancellation Policy

Please be advised that our office requires a two (2) business day notification of any changes to all scheduled dental appointments. You *MUST* speak with a team member for this. Any changes that are made after two business days will be subject to a **$50.00** cancellation fee.

While every attempt is made to confirm scheduled appointments with our patients, this fee also applies to appointments that the patient fails to show up for.

Please sign below, acknowledging that you are aware of our policy.

_____ _____

Signature Date

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ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____
_____
_____
_____

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Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Phone Number: _____

Date of Birth: _____ Address: _____

☐ I hereby authorize Cascades Center for Dental Health to disclose the following health information to: _____

☐ I hereby authorize _____ to disclose the following health information to Cascades Center for Dental Health.

Specific Information to be Released:

1. Information to be disclosed:
   - ☐ Medical record from this date _____ to this date _____
   - ☐ My entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

   Comments:
   _____
   _____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate (s) that I do NOT permit information of the following type, if it exists, to be released. I understand that if I do not check the box, Cascades Center for Dental Health will release such information about me if it exists.
   - ☐ HIV/Aids Infection
   - ☐ Genetic Information
   - ☐ Mental Health
   - ☐ Sexually Transmitted Infections
   - ☐ Treatment for alcohol and/or drug abuse
3. I understand that my records are protected under the federal privacy laws and regulations as well as under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by the law.
4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Cascades Center for Dental Health. I understand that any previously disclosed information would not be subject to my revocation request.
5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

_____ _____
Print Name of Patient Date

_____ _____
Signature of Patient or Legal Representative (if applicable) Relationship to Patient

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