Cheney Dental Care - Dr. Kevin Sanders, DDS
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CHENEY DENTAL CARE

WELCOME

Print Name: Last_____ First_____ Date: _____

SS Number:_____ Birthday:_____ Gender: **(circle)** M | F | Other

Home Address: _____ City | State | Zip:_____

Phone: ( ) 2nd Phone: ( ) Email:_____

Primary Ins. Company: _____ Subscriber's Name: _____

Birthday: _____ Group #: _____ ID #: _____

Do you have a Secondary Ins. (**circle)** YES | NO _____

In the event of an emergency, whom should we contact? _____ Phone: ( )

Are you currently under the care of a physician? If so Name:_____ Phone: ( )

Who may we thank for referring you? _____

TERMS AND CONDITIONS: By Signature: **You are responsible** for all costs of dental treatment, copayment | Deductibles | and any portion insurance does not cover. I hereby authorize the release of information for all covered services to my insurance company. Int:_____
PRIVACY PRACTICES: We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information by contacting our HR department.
RELEASE of Dental information at your request. By Int: _____ You are given permission to share your records with another office, including a copy of X-rays | Perio Charts | Medical Conditions | Diagnostic Records.
FINANCIAL AGREEMENT: Please understand that your insurance is a contract between you, your employer, or union & your insurance company. We are not part of that contract. You are responsible for payment of your dental bill, whether or not you have insurance coverage. As a courtesy to you, we will be happy to bill your insurance claim.
All or part of this financial arrangement may be a private contract. Only treatment submitted through a dental insurance carrier that we are in contract with is subject to filed fees. This agreement is being executed under authority of RCW 48.43.085 as a responsibility for any services delivered outside the health care plan.
I understand that I am financially responsible for all charges accrued for my dental treatment.
I authorize the use of my signature on all insurance submissions. We desire to make dental treatment affordable to all our patients. Therefore, we offer 5% discounts for CASH | MILITARY | SENIOR. We also offer our in-house discount plan for patients who are not covered by any insurance plan. If you have any questions, please see our Financial Coordinator. Please understand that our responsibility is to provide you with the treatment that best meets your needs, not to try and match your care with insurance plan limitations. **We are not responsible for the collection of insurance payments or negotiating disputed claims. Some insurance providers have waiting periods- you are responsible for knowing your plan stipulations/ terms of service. We have no obligation and no way of verifying your plan stipulations.**
All services are due to be paid within ninety (90) days from the date of service, regardless of whether your insurance benefits have been received by this office. All treatment that requires laboratory services, a minimal down payment of $ 200.00 will be required at the initial appointment. A fee of $25.00 will be charged for returned checks. There may be a $75.00 charge for any missed appointments or appointments not canceled 48 hours before the appointment time. Int: _____

Signature_____

Our office is HIPPA compliant and is committed to meeting or exceeding the standard for infection control mandated by OSHA, the CDC, and the ADA.

Patient Dental and Medical Health History

Your Oral Health is Your Overall Health

Patient name (printed)_____ Date _____

Do you or have you had any of the following: **(Please circle each)**

GENERAL MEDICAL HISTORY
Y N Hospitalization for Illness/Injury
Y N Surgery of Any Kind

CARDIOVASCULAR (Heart & Circulation)
Y N Atrial Fibrillation
Y N Heart Attack (When: _____)
Y N Pacemaker/Defibrillator
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Congenital Heart Defect
Y N Congestive Heart Failure
Y N Infective Endocarditis (When: _____)
Y N Artificial Heart Valve/Heart Valve Repair (When: _____)
Y N Cardiac Stent (When: _____)
Y N High Blood Pressure
Y N High Cholesterol
Y N Stroke (When: _____)
Y N TIA (When: _____)
Y N Blood Thinners

SLEEP & FATIGUE
Y N Insomnia
Y N Sleep Apnea
Y N Chronic Fatigue
Y N Snoring

EYES, EARS & ORAL HEALTH
Y N Glaucoma
Y N Hearing Loss
Y N Lumps or Sores in the Mouth/Head/Neck

INFECTIOUS DISEASES
Y N Hepatitis (Type: _____)
Y N STI/STD/HPV
Y N HIV/AIDS
Y N Herpes/Cold Sores
Y N Shingles
Y N Measles/Chickenpox
Y N Tuberculosis (TB/Lung Disease)

CANCER & IMMUNE SYSTEM
Y N Cancer (Type: _____)
(When: _____)
(Treatment: _____)
Y N Immuno Compromised

NEUROLOGIC
Y N Alzheimer's/Dementia
Y N Epilepsy/Seizures/Fainting
Y N Neurological Disorder
Y N Frequent Headaches/Migraines
Y N Vertigo

AUTOIMMUNE
Y N Lupus/MS
Y N Rheumatic/Scarlet Fever
Y N Arthritis/Gout
Y N Autoimmune Disease
Y N Fibromyalgia

RESPIRATORY
Y N Asthma
Y N COPD/Emphysema

BLOOD DISORDERS
Y N Anemia/Clotting Disorder
Y N DVT/PE
Y N Hemophilia
Y N Blood Transfusions

GASTROINTESTINAL
Y N Ulcers/Colitis
Y N Acid Reflux/GERD
Y N Digestive/Eating Disorder
Y N Crohn's Disease
Y N Liver Disease/Cirrhosis

ENDOCRINE & METABOLIC
Y N Diabetes (Type: _____ Last A1C _____)
Y N Low/High Thyroid
Y N Hormone Deficiency/Imbalance

KIDNEY & URINARY
Y N Kidney Disease
Y N Dialysis
Y N Kidney Transplant

BONE & MUSCULOSKELETAL
Y N Bisphosphonate Use
(Type: _____ When: _____)
Y N Osteoporosis
Y N Artificial Joints
Y N Head/Neck injuries (When: _____)

MENTAL HEALTH & SUBSTANCE USE
Y N Anxiety/Depression
Y N Psychiatric Problems/Mood Disorders
Y N Alcohol/Drug Use

Y N Do you have any other medical problems or medical history NOT listed:_____

_____

Are you pregnant? Yes No If Yes- Week#_____ Are you Nursing? Yes No

Are you using a prescribed method of Birth Control? Yes No If YES- Please read

* I have informed my dentist about my use of birth control. I have been advised that certain antibiotics may reduce the effectiveness of birth control. I agree to consult with my physician regarding birth control during the period of antibiotic treatment. Initial_____

PLEASE LIST **ANY ALLERGIES**, OR ADVERSE REACTIONS, INCLUDING BUT NOT LIMITED TO (ANESTHETICS | MEDICATIONS | MATERIALS | FOOD | SEASONAL)

Allergies:_____

CURRENT MEDICATIONS/ SUPPLEMENTS:_____

_____

Y N Consumed alcohol within the last 24 hours?

Y N Do you Smoke, Vape, or use **tobacco**? If yes, how much per day? _____How many years?_____

Y N Do you Smoke, Vape, or use **marijuana**? If yes, how much per day? _____How many years?_____

Y N Do you consume Caffeine? _____cups/day

I ATTEST THAT THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE_____ DATE_____