

Cascade Dental

Chris M. Jolley, DDS

Patient Information:

Name: _____ I prefer to be called: _____
Date of birth: ___/___/___ SS#: _____ Address: _____
City: _____ State: _____ Zip: _____ E-mail: _____
Home: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Responsible Party:

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
E-mail: _____

Insurance Information:

Name of Insured: _____ DOB: _____ Relationship to Patient: _____
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____
Insurance Company: _____ Grp # _____ ID# _____
Ins Co Address: _____ Ins Co. Phone: (____) _____
Do you have any additional dental insurance? Yes No

Emergency contact _____ Emerg. Phone(____) _____
Pharmacy _____ Whom may we thank for referring you? _____
Have you visited www.DrChrisJolley.com? Yes No

Medical History:

Yes No Are you being treated for anything by a physician?
Yes No Do you currently take any medications, including birth control pills or aspirin?
Yes No Have you ever used Phen-Fen or other appetite suppression combinations for weight loss?
Yes No Do you bleed or bruise easily?
Yes No Are you allergic to any medicines or latex?
Yes No Have you ever had a reaction to any metals or jewelry?
Yes No Have you ever had a severe reaction to dental treatment or local anesthetics?
Yes No Have you ever received counseling for excessive use of alcohol or prescription drugs?
Yes No Women: Are you pregnant?
Yes No Are you in any pain?
Yes No Are you fearful or anxious of dental treatment?
Yes No Is there anything about the appearance of your teeth that you would like to change?

Please circle if you have ever had any of the following conditions:

HIV or AIDS heart disease blood disorder heart murmur artificial joint high blood pressure
hepatitis liver disease rheumatic fever asthma diabetes arthritis tuberculosis seizures
venereal disease heart attack kidney disease fainting psychiatric disorder immunity disorder

initials _____

Health Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Jolley and/or associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac, stimulation, temporary or rarely, permanent numbness, and muscle soreness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Notice of Privacy Practices/Patient Acknowledgment

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual right with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains.

initials _____

Office Financial Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services finished 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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ½% per month (18% per annum) or the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, thereof, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. 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 a suit is instituted hereunder to collect monies owed by me. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have answered all questions on all pages of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature: _____ Date (mm/dd/yyyy) ____/____/_____
(Patient, legal guardian, or authorized agent of patient)

Witness: _____ Date (mm/dd/yyyy) ____/____/_____