Welcome

Name_____
Address_____
City_____ State_____ Zip_____
Who may we thank for referring you? _____
Home Phone_____ Work_____
Cell Phone #1_____ Cell Phone #2_____
Email Address: _____
Birth Date_____
Social Security # of Patient_____
Sex: Male or Female
Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

Insurance Information

The information provided below **WILL BE** the Primary Insurance Company we use to submit your dental treatment. **La Casa Dental does not file secondary insurance**. We will assist you with the necessary paperwork to file your secondary. If your dental insurance changes at any time it is your responsibility to notify our staff. Thank you for your understanding.

Primary Insurance Holder's Name_____
Date of Birth_____ Social Security #_____
Home Address if Different from Above_____
Relationship to Patient_____
Name of Employer_____
Occupation_____
Business Address_____
Name of Insurance Phone_____
Policy or Group Number_____
Insurance Mailing Address_____
Insurance Phone Number_____
Name of other Family members under this plan:
_____

Dental History

Are you in discomfort today? _____
What are your expectations for treatment? _____
How long has it been since your last visit to a Dentist? _____

Name of Former Dentist _____ Phone # _____
Address_____
City _____
State _____

Did they take any x-rays? _____ If so, may we call them to be forwarded? _____

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How do you feel about your teeth? _____
How often do you brush? _____ Floss? _____
Have you ever experienced an adverse reaction during any medical or dental procedure? If yes, explain.
_____

Medical History

Physician's Name _____
Phone # _____ Date of Last Visit _____
Are you under the care of a doctor at this time? _____
Have you had any serious illness or operations? _____
If yes, please describe _____
_____
Have you ever had a blood transfusion? _____ If yes, give the date _____
Have you ever taken Fen-Phen or Redux? _____
Women: Are you pregnant? _____ Nursing? _____ Taking Birth Control Pills? _____

Please Circle YES or NO if you have had any of the following:

Y or N AIDS/HIV Positive
Y or N Pacemaker/Heart Surgery
Y or N Anaphylaxis
Y or N Anemia
Y or N Arthritis
Y or N Artificial Heart Valves
Y or N Artificial Joints
Y or N Back Problems
Y or N Cancer
Y or N Chemotherapy
Y or N Circulatory Problems
Y or N Cortisone Treatments
Y or N Cough, persistent
Y or N Cough up Blood
Y or N Diabetes
Y or N Epilepsy
Y or N Fainting
Y or N Food Allergies
Y or N Glaucoma
Y or N Headaches
Y or N Heart Murmur
Y or N Hepatitis
Y or N Herpes
Y or N High Blood Pressure
Y or N Kidney Disease
Y or N Material Allergies
(latex, wool, metal, chemicals)

Y or N Asthma
Y or N Psychiatric Care
Y or N Radiation Therapy
Y or N Respiratory Disease
Y or N Rheumatic/Scarlet Fever
Y or N Shingles
Y or N Shortness of Breath
Y or N Skin Rash
Y or N Spinal Bifida
Y or N Stroke
Y or N Surgical Implant
Y or N Swelling of Feet or Ankles
Y or N Thyroid Disease
Y or N Tobacco Use
If so, what and how much per day
_____
Y or N Tonsillitis
Y or N Tuberculosis
Y or N Ulcer/Colitis
Y or N Venereal Disease
Y or N Jaw Pain
Y or N Liver Disease
Y or N Hemophilia/Abnormal
Y or N Mitral Valve Prolapse
Y or N Any History of Drug Abuse
If so please describe: _____
_____
_____
_____

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What Pharmacy do you use: _____

Is Patient Currently Taking Any Medication? If yes, please list all:

_____

_____

_____

Does Patient Have Any Drug Allergies? If yes, please list all:

_____

_____

_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Hasse to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Hasse. I authorize the insurance company indicated on this form to pay Dr. Hasse all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____

Patient/Guardian Signature Date

Office Uses Only, Please Do Not Write Below This Line

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Payment Options

To help keep cost of **DENTISTRY** down and to continue to provide quality care to our valued patients, we now only accept **Payment in Full** the day of treatment.

*Please (√) the option(s) most convenient for you to settle your account in full today.

- ☐ **CASH/CHECK/DEBIT**
- ☐ **VISA** Acct. # _____ Exp. Date_____
- ☐ **MC** Acct. # _____ Exp. Date_____
- ☐ **DISC** Acct. # _____Exp. Date_____
- ☐ **In House Credit Plan**

  (CARECREDIT) Please see receptionist for application form.

  Name on Card: _____
  Address: _____
  Zip Code: _____

I _____ hereby authorize **La Casa Dental Office** to process payments, from time to time, as the dental office deems necessary, to settle my account in full.

_____ _____
Patients Signature Date

_____ _____
Witness Date

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Consent to Perform Dentistry

1.) I hereby authorize and direct the dentist(s) of La Casa Dental and or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

- A. Preventive hygiene treatment (prophylaxis) and the application of fluoride.
- B. Application of plastic "sealants" to the grooves of teeth.
- C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
- D. Replacement of missing teeth with dental prostheses. (bridges, partial dentures, full dentures)
- E. Removal (extraction) of one or more teeth.
- F. Treatment of diseased or injured oral tissue (hard and/or soft).
- G. Use of sedative drugs to control apprehension and/or disruptive behavior
- H. Treatment of malposed (crooked) teeth and/ or oral developmental or growth abnormalities.
- I. Use of general anesthesia to accomplish the necessary treatment.

2.) I understand that there are risks involved in this treatment and hereby acknowledge that these risk (s) will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3.) I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4.) I recognize that during that course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

5.) There are possible risks are complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6.) I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

7.) I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8.) I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9.) I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient Name: _____ Date _____

Signature of Patient _____

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Signature on File

Patient Name_____
(Please Print)

( ) I authorize use of this form on **all** my insurance submissions.
( ) I authorize release of information to my **Insurance Company**
( ) I understand that **I am responsible** for my bill
( ) I authorize my doctor to act as **my** agent in helping me obtain payment from my insurance company.
( ) I authorize payment directly to my doctor.
( ) My signature also applies to the dependents listed below.

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____
6.) _____

Patient Signature_____ Date_____