Karlie A. Gaskins, D.D.S., P.L.L.C.
Family & Cosmetic Dentistry
4586 SE Mile Hill Dr., Suite A101
Port Orchard, WA 98366
Tel 360 769 0667
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Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: ☐ M ☐ F **Status**: Married Single Divorced Widowed Child **Social Security** #: _____

Date of Birth: _____ **E-mail**: _____ **WDL#**: _____

Phone: (Home): _____ **(Cell):** _____ **(Work):** _____ Ext: _____

Address: _____
Street Apartment #/Suite #

_____
City State Zip Code

Patients Relationship to Insurance Subscriber: ☐ **Self** ☐ **Child** ☐ **Spouse** ☐ **Other:** _____

Patients Employer Name: _____ Patient Occupation: _____ If student ☐

Address: _____
Street City, State Zip Code Phone

Referral Information

Whom may we thank for referring you to our practice? _____

Spouse/Guardian/Person ultimately Responsible for Account: ☐ Patient's spouse ☐ Person responsible for Payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date**: _____ **WDL#:** _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information:

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary Insurance Carrier:

Insurance Plan Name and Address: _____

Name of Subscriber: _____ **SSN#:** _____
Last First MI

Subscriber Birth of Date: _____ **ID #:** _____ **Group #:** _____

Subscriber's Employer's Group Name: _____

Patient's relationship to this Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Carrier:

Insurance Plan Name and Address: _____

Name of Subscriber: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Employer's Group Name: _____

Patient's relationship to this Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patients Health Information

General Health: ☐ Good ☐ Fair ☐ Poor

• Name of Physician: _____ Phone: _____

Are you currently taking any medications: ☐ Yes ☐ No If yes, please list name and reason for use below:

_____

_____

_____

_____

Are you allergic to any medications: ☐ Yes ☐ No If yes, please mark below or list reaction as needed:

☐ Penicillin ☐ Codeine ☐ Latex ☐ Local anesthetics _____

Please mark the following that apply to your Medical history: or ☐ if none mentioned below

☐ Need antibiotics prior to dental work
☐ Artificial joint replacement
☐ Undergone radiation or IV chemotherapy
☐ Taken any medications for osteoporosis
☐ Subject to prolonged bleeding
☐ Use or have used tobacco products in the past
☐ Excessive thirst and/or urination
☐ Subject to fainting
☐ Recently hospitalized or major surgeries _____
☐ Pacemaker
☐ Currently pregnant or nursing / Due Date: _____
If yes to tobacco, what type and how often_____

Have you ever dealt with or are currently being treated for the following? Please check those that apply:

☐ Heart Disease
☐ Heart Murmur
☐ Rheumatic Fever
☐ Artificial Joints
☐ Congenital Heart Defects
☐ Diabetes (Type:)
☐ Cancer (Type:)
☐ Abnormal Blood Pressure
☐ Osteoporosis
☐ Epilepsy or Seizures
☐ Anemia
☐ Stroke
☐ Mitral Valve Prolapse
☐ Acid Reflux
☐ Head Injuries
☐ Stomach Problems
☐ Ulcers / colitis
☐ Hepatitis (Type:)
☐ Eating disorders
☐ Jaundice
☐ Excessive Bleeding
☐ Arthritis
☐ Thyroid Disease hypo/hyper
☐ Glaucoma
☐ Hemophilia
☐ Neck or back problems
☐ Autoimmune disorder
☐ Respiratory Problems
☐ Kidney Disease/ Dialysis
☐ Hay Fever
☐ Sinus Problems
☐ Frequent headaches
☐ Jaw problems TMJ/TMD
☐ Tuberculosis
☐ HIV/ AIDS
☐ Venereal Disease
☐ Drug or Substance Addiction
☐ Recreational drug use
☐ Mental Disorders
☐ Cosmetic surgery
☐ Shingles
☐ Sleep Apnea
☐ Allergies _____
☐ None of the above

• Do you have any health problems or Medical conditions that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Office use only- BP: Pulse: Reviewed by:_____ Date:_____

Emergency Contact

Name of Relative or Person *NOT LIVING* with you: _____
Phone:_____ Address: _____

DENTAL HISTORY

Date of Last Dental Visit: _____ Reason for this visit: _____

How often do you brush? _____
What dental aids do you use? ☐ Floss ☐ Water pick ☐ Toothpick ☐ Electronic/Sonicare toothbrush ☐ Perio Aid ☐ Other
Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Are you familiar with the term 'Preventive Dentistry'?..... ☐ Yes ☐ No
When used properly, do you believe in the dental benefits of Fluoride?..... ☐ Yes ☐ No
Do you plan on maintaining your teeth for the rest of your life?..... ☐ Yes ☐ No

Please mark the following that apply to you:

- ☐ Gums bleed during brushing or flossing
- ☐ Gums feel tender or swollen
- ☐ Pain with brushing or flossing
- ☐ Frequent sensitivity to cold, hot or sweets
- ☐ Usually break fillings or teeth
- ☐ Pain with biting or chewing
- ☐ Jaws frequently feel tired or sore
- ☐ Regularly clench or grind your teeth
- ☐ Bad odors or tastes in mouth
- ☐ Use or have used a mouthguard or splint
- ☐ Frequent cold sores, blisters or other oral/lip lesions
- ☐ Food gets caught between teeth
- ☐ Previous or current Periodontal (gum) surgery/treatment
- ☐ Previous orthodontics (braces)
- ☐ Previous injury or trauma to your teeth, mouth or face
- ☐ Previous biopsy of mouth, lips or face
- ☐ Either took fluoride as a child or grew up in a fluoridated community
- ☐ Currently using a tartar control, whitening or baking soda toothpaste

To the best of my knowledge, all of the proceeding 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.

_____ Date: _____
Signature of patient, parent or guardian

Consent for Services (Please sign unless you have any question)

I hereby authorize this Dental Practice to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for Payment: In the event that this matter is turned over to a collection agency or attorney for collection of any kind of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth.

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 and the attached Office Financial Policy and agree to their content.

_____Date:_____Relationship to Patient_____
Signature of patient if minor have Parent/Guardian signature

Karlie A Gaskins, DDS, PLLC. **4586 SE Mile Hill Dr. Ste-A101, Port Orchard, WA 98366 360-769-0667**

Please see reverse for financial policies.

Karlie A Gaskins, DDS, PLLC Office Policies

Please review and sign at the bottom, acknowledging that you were informed of these policies.

FINANCIAL POLICY

In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end. To assist our patients, we offer the following methods for taking care of their account at our office:

- We offer a 5% discount, when you pay by cash or check on the day of service for patients who do not use insurance
- We accept credit cards (Visa, Mastercard) but no discount will be given as we pay a credit user fee
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you either pay your portion of the bill at the time of service, or that a suitable written financial agreement be reached at the time of service. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. You must address all questions regarding payment of benefits and coverage to your insurance carrier, as you are the subscriber and have an agreement with your dental insurance company. You are ultimately responsible for payment of your account.
- For patients who qualify, we offer various payment plans through a third party Financing Company. There are numerous payment options that will fit comfortable in almost any monthly budget. These companies offer a revolving line of credit that can be used by the whole family for ongoing treatment without having to reapply. There are no upfront costs, pre-payment penalties or annual fees to our patients

FAILED OR CANCELLED APPOINTMENTS

We kindly ask that patients give us 24-hour notice, if they are unable to keep an appointment. There will be a $25 *minimum* charge for failed appointments. The length of time reserved and the number of prior appointments determined your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice. You may leave a message on our after-hours message phone, if you find out that you are unable to honor an appointment after our office has closed for the day.

ESTIMATES AND FEES

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. Except in extreme emergencies, financial arrangements are made before treatment is rendered. There is a service charge on all unpaid accounts.

DELIQUENT ACCOUNTS

Delinquent accounts which have to be turned over to a Credit Reporting Collection Agency will have their balances increased 50% to cover the expenses associated with the Collection Agency. In addition to these expenses, delinquent accounts are also liable for Attorney fees and court costs associated with the collection of the debt.

CARE TO SHARE REFERRAL

We believe that referrals are the best compliment. We'd like to reward you for sharing your good experience here with others. For every family you refer to our office, we will gift both you and them a $25 credit to use towards services at our office. Please make sure you let us know who referred you and make sure your friends let us know you referred them!

NOTICE OF PRIVACY PRACTICES (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is attached to this New Patient paperwork which you are being asked to complete. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

Please let us know if you have any questions or concerns about any of our Office Policies; otherwise please sign below:

Patient or Responsible Party Signature: _____ Date _____