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
Fax 360 769 0675

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**: _____

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? _____

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 _____

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

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 they let us know you referred them in the future!

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 ____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
26. osteoporosis/osteopenia (e.g., taking bisphosphonates) _____	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐

ARE YOU:

47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6) ☐○☐

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/___

Date of most recent treatment (other than a cleaning) ___/___/___

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		**YES**	**NO**
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		**YES**	**NO**
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		**YES**	**NO**
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		**YES**	**NO**
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____