CASCADE DENTAL CARE

cascadedentaldds.com
1425 Wakarusa Dr | Suite A • Lawrence, KS 66049
cascadedentalks@gmail.com
(785)841-3311

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

How did you hear about our office?

☐ Internet ☐ Social Media ☐ Newspaper ☐ Friend or Family ☐ School ☐ Work ☐ Dental Office

If friend or family, who may we thank?

_____

_____

When was the date of your last dental visit? _____

Do you have an Emergency Contact Name & Phone Number? What is their Relationship to you?

_____

_____

_____

Dental Information

Do you have any clicking, popping or discomfort in the jaw? ◯ Yes ◯ No

Do you clench or grind your teeth? ◯ Yes ◯ No

Have you ever had a serious injury to your head or mouth? ◯ Yes ◯ No

Are your teeth sensitive to:

☐ Hot? ☐ Cold? ☐ Sweet? ☐ Pressure?

Have you had any periodontal(gum) treatments? ◯ Yes ◯ No

Had you had any problems associated with previous dental treatment? ◯ Yes ◯ No

Are you currently experiencing dental pain or discomfort? ◯ Yes ◯ No

Explain if yes:

_____

_____

Medical and Dental History

Please check all of the following that apply currently

- ☐ Acid Reflux
- ☐ AIDS
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Gums
- ☐ Previous Infective Endocarditis
- ☐ Cancer
- ☐ Chemotherapy/Radiation Treatment
- ☐ Cold Sores
- ☐ Dental Anxiety
- ☐ Diabetes Type 1 or II
- ☐ Dizziness
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Migraine Headaches
- ☐ Neurological Disorders
- ☐ Recurrent Infections
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Sinus Problems
- ☐ Snore
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Other Conditions:

_____

_____

Women only: If pregnant, when is your due date?

_____

_____

Have you ever been told you require a pre medication prior to dental treatment? ◯ Yes ◯ No

If answered 'yes', please explain

_____

_____

Have you had an Orthopedic Total Joint (hip,knee,elbow,finger) Replacement? ◯ Yes ◯ No

Please Explain:

_____

_____

_____

Allergies

Please check all that apply

- ☐ Local Anesthetics
- ☐ Barbiturates, Sedatives, or Sleeping Pills
- ☐ Metals
- ☐ Hay Fever/Seasonal Allergies
- ☐ Aspirin
- ☐ Sulfa Drugs
- ☐ Latex (rubber)
- ☐ Animals
- ☐ Penicillin or other Antibiotics(Keflex.Clindamycin)
- ☐ Codeine or other Narcotics
- ☐ Iodine
- ☐ Food

Other

_____

_____

If you currently smoke, what product do you use?

☐ cigarette ☐ cigar ☐ smokeless tobacco ☐ vape

What is the frequency of your use?

Have you been admitted to a hospital or needed emergency care during the past 2 years? ◯ Yes ◯ No

If yes, please explain

Name of physician

Have you seen your physician in the last year? ◯ Yes ◯ No

Preferred Pharmacy?

Please list all medications you are currently taking. Both prescription and over the counter.

By checking this box, I acknowledge that to the best of my knowlege all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

◯ Yes ◯ No

Response Date: _____

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Insurance Information

Name of Insured: _____* _____* ____
Last First MI

Insured's Birth Date:* _____ **ID #:*** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ____ ____-____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ ____-____
City State Zip Code

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ____ ____-____
City State Zip Code

Name of Insured: _____* _____* ____
Last First MI

Insured's Birth Date:* _____ **ID #:*** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

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_____ ____ ____-____
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_____ ____ ____-____
City State Zip Code

Response Date: _____