Cheney Dental Care- Dr. Andrew F. Martinssen, DDS | Dr. Stacey McDonald DMD | Dr. Joshua Lansing DMD
625 B Street Cheney, WA 99004 | (509) 960-6020 | info@cheneydentalcare.com | www.cheneywadentist.com

CHENEY DENTAL CARE

WELCOME

Print Name: Last_____ First_____ Date: _____

SS Number_____Birthday _____ Gender: (circle) M | F | Other

Home address: _____City | State | Zip_____

Phone ( ) 2nd Phone ( ) Email_____

Primary Ins. company_____Phone ( ) Plan Name:_____

Insured'same_____Birthday_____Group #_____

ID # _____Do you have a Secondary Ins. YES | NO_____

In the event of an emergency, whom should we contact?_____Phone ( )

Are you currently under the care of a physician, If so Name_____Phone ( )
Who may we thank for referring you?_____

TERMS AND CONDITIONS: By Signature: You understand that this office will bill your insurance for treatment Provided. **I am responsible** for all costs of dental treatment, copayment | deductibles | and any portion insurance does not cover. I hereby Authorize release of information, for all services completed treatment to my insurance company. Int:_____

PRIVACY PRACTICES: We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record . We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about by contacting our HR department. Int: _____

RELEASE of Dental information at your request. By Int: _____ You are given permission to share your records with other office, including copy of X-rays | Perio Charts | Medical conditions | diagnostic records.

FINANCIAL AGREEMENT: Please understand that your insurance is a contract between you, your employer or union & your insurance company. We are not part of that contract. You are responsible for payment of your dental bill, whether or not you have insurance coverage. As a courtesy to you we will be happy to bill your insurance claim. **All or part of this financial arrangement may be a private contract. Only treatment submitted through a dental insurance carrier is subject to filed fees. This agreement is being executed under authority of RCW 48.43.085 as a responsibility for any services delivered outside the health care plan.** I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. We desire to make dental treatment affordable to all our patients. Therefore, we offer 5% discounts for
CASH | MILITARY | SENIOR. We also offer our in house cash plan for patients who are not covered by any insurance plan. If you have any questions please see our Financial Coordinator. Please understand that our responsibility is to provide you with the treatment that best meets your needs, not to try and match your care with insurance plan limitations. **We are not responsible for collection of insurance payments or negotiating disputed claims.Some insurances have waiting periods- You are responsible for knowing this. We have no way of knowing this info.**
All services are due to be paid within ninety (90) days from the date of service, regardless as to whether your insurance benefits have been received by this office. A finance charge of 1.5% per month will be applied on account after 90 days. All treatment that requires laboratory services, a minimal down payment of $ 200.00 will be required at the initial appointment. A fee of $25.00 will be charged for returned checks. There may be a $75.00 charge for any missed appointments or appointments not canceled 48 hours before the appointment time. Int: _____

Signature_____

Our office is HIPPA Compliant and is committed to meeting or exceeding the standard for infection control mandated by OSHA, the CDC and the ADA.

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Welcome, are you a new patient establishing care? Or do you have a specific concern.

Estimate date of last cleaning _____

Are you nervous about seeing a dentist? ƒYes ƒNo If yes, please tell us why:

Have you ever had ***problems*** with any past dental Treatment?_____

How often do you brush (Circle One) 2xDay 1xday Other

I have sensitivity when brushing (Circle all that apply) UR, LR, UL, LL

How often do you floss (Circle One) 1xDay 3xWeek 1xWeek Other

(Please circle each)

Y N My gums feel tender or swollen

Y N My gums bleed while brushing or flossing

Y N I have had a facial or jaw injury

Y N I had orthodontics

Y N **Do you like your Smile**

I consider my health to be (circle one) Excellent Good Fair Poor

Do you or have you had any of the following: **(Please circle each)**

Y N Heart attack//Pacemaker	Y N Kidney Problems	Y N Abnormal/Prolonged Bleeding
Y N Heart Murmur	Y N Shingles	Y N Cancer/Chemotherapy
Y N Mitral Valve Prolapse	Y N Rheumatic/Scarlet Fever	Y N HIV/AIDS
Y N Liver Disease/Jaundice	Y N Alcohol/Drug Abuse	Y N Radiation Treatment
Y N Immune Suppressed Disorder	Y N Lupus	Y N Tuberculosis (TB/Lung Disease)
Y N Hepatitis Type _____	Y N Arthritis	Y N Blood Transfusion
Y N Glaucoma	Y N Anemia	Y N Ulcers/Colitis
Y N Stroke	Y N Herpes/Fever Blisters	Y N Venereal Disease
Y N Hearing Loss	Y N Hemophilia	Y N I have had major surgery
Y N Congenital Heart Defect	Y N Excessive Urination/Thirst	Y N Artificial Bones/Joints

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Women ONLY: Are you pregnant ƒYes ƒNo Week #_____ Are you Nursing? ƒYes ƒNo

Are you using s prescribed method of Birth Control ƒYes ƒNo If YES- Please read and Initial_____

I have informed my Doctor about my use of birth control pills. I have been advised that certain antibiotics and dental Anesthesia may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my physician to initiate additional forms of birth control during the period of my treatment.

SLEEP (Please circle each)

Y N Epilepsy/Seizures/Fainting	Y N Emphysema | Asthma	Y N Psychiatric Problems
Y N Diabetes Type _____	**Y N** High/Low Blood Pressure	Y N Have you been told that you snore
Y N Difficulty Breathing	Y N Have you ever been diagnosed with sleep apnea	
Y N Do you have trouble sleeping or staying asleep?		Y N Wear a CPAP-or been told you need one
Y N Insomnia	Y N Anxiety	Y N Frequent headaches/migraines
Y N Fibromyalgia	Y N Low/High Thyroid	Y N Frequent urination @night

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Y N Consumed alcohol within the last 24 hours

Y N Do you Smoke, Vapeor use tobacco? If yes, how much per day? _____How many years?_____

Y N Do you have any other medical problems or medical history NOT listed

DO YOU HAVE ANY **ALLERGIES**, OR REACTIONS ƒYes ƒNo (Anesthetics | Medications | Materials)

MEDICATIONS:_____

ANESTHETICS CONSENT: Possible side effects-Hematoma, Trismas, Body temp, Nausea, Headache.For more ask desk Initial_____

I UNDERSTAND THAT INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT AND TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE_____DATE_____