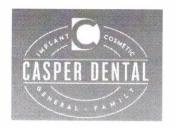


Dr. Brent Casper, D.D.S. FAMILY, COSMETIC & IMPLANT DENTISTRY

www.yourtridental.com 509.943.4242 725 Swift Blvd Richland, WA 99352

	WELCOME TO OU	R OFFICE ~ WE LOOK FORWARD TO	O GETTING TO KNOW YOU
Date: Patient:	***************************************	****	New Patient UPDATE
raucii.	LAST	First MI	PREFERRED TITLE
	MALE FEMALE	CHILD STUDENT	Single Married Divorced Widowed
Patient Da	ite of Birth:	Patient SSN	
Address:			
	ADDRESS LINE 1		
	Appress Line 2		HOME:
	ADDRESS LINE 2		TEXT
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		OK?:
=	Сіту	ST ZIP CODE	*******************************
E-Mail:			
R	eferral?	Whom may we thank for referring you:	***************************************
		EMERGENCY CONTACT	
			Tel:
NAME		RELATIONSHIP	
		EMPLOYMENT INFORMATIO	
Employer:			***************************************
		DENTAL HISTORY	
Previous D	Dentist/clinic:	Reason for	
	***********	change:	
		_INSURANCE INFORMATIO	N
rimary Ir	nsurance Information		
	sured:		nsured: SelfSpouse Child Other
sured Soc.Sec:			te:
mployer:			
ddress:			
ddress 2:			
	Zip:		
econdar	y Insurance Informati	ion	
	•	1011	
anno or ma	sured:		nsured: SelfSpouse Child Other
sured Soc	sured: c.Sec:	Relationship to I	
sured Soc	c.Sec:	Relationship to I	te:
sured Soc nployer:	c.Sec:	Relationship to I Insured Birth Da Ins. Company:	te:
sured Soc mployer: ddress:	c.Sec:	Relationship to I Insured Birth Da Ins. Company: Address:	nsured: SelfSpouse Child Otherte:



## Dr. Brent Casper, D.D.S.

FAMILY, COSMETIC & IMPLANT DENTISTRY

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MEDICAL H	ISTORY
GENERAL HEALTH: DEXCELLENT GOOD FAIR POOR PRIMARY PHYSIC	CIAN:
Y□N       Under a physician's care now?         Y□N       Any hospitalization in the past 5 years?         Y□N       Any serious illnesses/surgeries?         Y□N       Use tobacco in any form? If Yes, Type:         Y□N       Is pre-medication required before dental visits due to the past of t	rugs? If yes, list details in the Medication Section. rrently pregnant? Due Date:
ADHD CANCER/MALIGNANCY  AIDS/HIV CEREBRAL PALSY  ANEMIA CHEMICAL DEPENDENCY  ANOREXIA CONVULSIONS  ANXIETY DEPRESSION  ARTIFICIAL HEART VALVE DIABETES  ARTIFICIAL JOINTS DIZZINESS/FAINTING  ARTHRITIS EPILEPSY/SEIZURES  ASTHMA FREQUENT EAR INFECTIONS  AUTISM/ASPERGER'S FREQUENT HEADACHES  BLEEDING DISORDER HEARING PROBLEMS  ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY	OLLOWING? (CHECK ALL THAT APPLY):  HEART ATTACK  HEART DISEASE  HEART MURMUR  HEART MURMUR  HEPATITIS  HIGH BLOOD PRESSURE  KIDNEY DISEASE  LIVER PROBLEMS  MITTAL VALVE PROLAPSE  MONONUCLEOSIS  PACEMAKER  OTHER — PLEASE LIST:  Y REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):
ASPIRIN CODEINE LACTOSE INTOLERANCE  ANESTHETIC – LOCAL DAIRY METAL SENSITIVITY  BARBITURATES LATEX NITROUS OXIDE SEDA  OTHER – PLEASE LIST:	Sulfa Drugs
MEDICATION INF	ORMATION
ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING  ANTIBIOTICS/SULFA DRUGS  BLOOD THINNERS  CANCER/CHEMO MEDICATIONS  NITROGLYCERIN  OTHER DIABETIC MEDICATIONS  OTHER (PLEASE LIST BELOW)	PROPERTY OF THE PROPERTY OF TH
DRUG NAME (OR WE CAN COPY YOUR LIST) DOSAGE	REASON PRESCRIBED

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Casper Family Dental Dr. Brent Casper, DDS 725 Swift Blvd Richland, WA 99352 (509) 943-4242

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I understand that I may review practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain my revised notices at the practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature:	_Date:
Patient, parent or legal guardian	
If signed by patient representative, state relationship to patien	nt:
Dependent family members also covered by this acknowledge	ment:
For Office Hee Only	

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practice due to the following reason:

- The patient refused to sign
- Communication barrier
- Emergency situation
- Other