CASPER DENTAL

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

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

WELCOME TO OUR OFFICE ~ WE LOOK FORWARD TO GETTING TO KNOW YOU

Date: _____ ☐New Patient ☐Update

Patient: _____
LAST FIRST MI PREFERRED TITLE

☐Male ☐Female ☐Child ☐Student ☐Single ☐Married ☐Divorced ☐Widowed

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

HOME: _____
CELL: _____
TEXT OK?: _____

E-Mail: _____

Referral? ☐Yes ☐ No Whom may we thank for referring you: _____

EMERGENCY CONTACT

_____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

DENTAL HISTORY

Previous Dentist/clinic: _____ Reason for change: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Are your teeth sensitive? ☐to cold ☐to hot ☐to sweets ☐when biting

What factors are most important for your satisfaction with our office?

_____

INSURANCE INFORMATION

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: __ Self __Spouse __ Child __ Other
Insured Soc.Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: __ Self __Spouse __ Child __ Other
Insured Soc.Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2_ _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

CASPER DENTAL
IMPLANT COSMETIC GENERAL FAMILY

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR PRIMARY PHYSICIAN:

☐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 heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

_____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEART ATTACK	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART DISEASE	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART MURMUR	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEPATITIS	☐RHEUMATIC FEVER
☐ANOREXIA	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐SINUS PROBLEMS
☐ANXIETY	☐DEPRESSION	☐KIDNEY DISEASE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DIABETES	☐LIVER PROBLEMS	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐TUBERCULOSIS
☐ARTHRITIS	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐ULCERS
☐ASTHMA	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐AUTISM/ASPERGER'S	☐FREQUENT HEADACHES		
☐BLEEDING DISORDER	☐HEARING PROBLEMS	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS	

☐OTHER – PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME (OR WE CAN COPY YOUR LIST)	DOSAGE	REASON PRESCRIBED

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Casper Family Dental
Dr. Brent Casper, DDS
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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 patient: _____

Dependent family members also covered by this acknowledgement:

_____

For Office Use 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