

# Cassity Implants

*"Advanced techniques for more comfortable care."*

South Ogden  
5331 S Adams Ave. Suite A  
801-475-5577

Kaysville  
347 N. 300 W. Suite 201  
801-444-2696

## PATIENT INFORMATION

Patient Name in Full: \_\_\_\_\_ Preferred: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone: ( ) - \_\_\_\_\_ Mobile Phone: ( ) - \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Email: \_\_\_\_\_ **General Dentist:** \_\_\_\_\_  
SSN: - - \_\_\_\_\_ DL State/#: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: ( ) - \_\_\_\_\_  
**Whom may we thank for referring you?** \_\_\_\_\_  
**RESPONSIBLE PARTY** (if different from above)

- MALE
- FEMALE
- MARRIED
- SINGLE
- DIVORCED
- WIDOWED
- MINOR

Person Responsible for Account: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Primary Phone: ( ) - \_\_\_\_\_ SSN: - - \_\_\_\_\_ DL State/#: \_\_\_\_\_

## INSURANCE INFORMATION

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Primary Phone: ( ) - \_\_\_\_\_ Birthday: / / \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Member ID#: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Primary Phone: ( ) - \_\_\_\_\_ Birthday: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Member ID#: \_\_\_\_\_

## AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to C & F Implants all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. If I do not pay the entire new balance within 30 days of the monthly billing date, a periodic service charge rate of 1.5% per month will be added to the account, which is an annual percentage rate of 21% applied to the last month's balance. The undersigned further agrees to pay an additional amount representing up to 50% of the principal balance if the account is referred to a collection agency or attorney for collection. The additional amount is in recognition of the costs associated with said collection action processing. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. If necessary, this office may share medical/dental information with my dentist or other specialists to help consult with what treatment may be best for me. **PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

## HEALTH HISTORY

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

General Dentist: \_\_\_\_\_

### DENTAL INFORMATION

Mark if you have had problems with any of the following:

<input type="checkbox"/> Cold or canker sores	<input type="checkbox"/> Injury to face, jaw or teeth
<input type="checkbox"/> Sensitivity to biting or pressure	<input type="checkbox"/> Clenching or grinding teeth
<input type="checkbox"/> Sensitivity to hot, cold or sweets	<input type="checkbox"/> Periodontal (gum) treatment
<input type="checkbox"/> Food trapped between teeth	<input type="checkbox"/> Orthodontic treatment (braces)
<input type="checkbox"/> Pain, clicking or popping of jaw	<input type="checkbox"/> Chronic Snoring
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Frequent day time sleepiness

### MEDICAL INFORMATION

The name & address of your physician	Yes	No
Are you in good health	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past year	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently under pain management	<input type="checkbox"/>	<input type="checkbox"/>
Name of pain management physician:		
Have you had any serious illness, operation or been hospitalized in the past 5 years	<input type="checkbox"/>	<input type="checkbox"/>
If so, what was the illness or problem		
<b>Are you taking any medication including non-prescription medicine?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, please list ALL medications are you taking:</b>		
Have you ever taken Fosamax, Actonel, Boniva or any drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer including IV or injectable drugs	<input type="checkbox"/>	<input type="checkbox"/>
Have you had abnormal bleeding associated with previous extractions, surgery or trauma	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever required a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any blood disorders such as anemia	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any treatment for a tumor or growth	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic or have you had a reaction to any drug or medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, what:</b>		
Have you had any serious trouble associated with any previous dental treatment	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, explain:</b>		
Do you use or have you used street drugs	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or use tobacco in any form, for how long	<input type="checkbox"/>	<input type="checkbox"/>
Do you use any alcohol products	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant/nursing	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills or hormones	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease or condition not listed above that we should be aware of	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, explain:</b>		

	Yes	No		Yes	No
AIDS or immunosuppressive disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Damaged or artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

**NOTES**


To the best of my knowledge, I certify that all of the proceeding answers are true, complete and accurate. Additionally, by my signature I hereby authorize Dr. Kim Cassity, DMD and/or his/her associates and/or hygienists and/or assistants as they may designate to perform those procedures including surgery as may be deemed necessary or advisable to treat my oral condition(s) including arrangements and/or administration of anesthetic, sedative analgesic, therapeutic and/or other pharmaceutical agent(s) including those related to restorative, palliative, surgical, anesthetic sedative, analgesic, medicinal or drug treatment(s) and to voluntarily assume the possible risks with these procedures. I also certify that no guarantee or assurance has been given to me that the proposed treatment will be curative and /or successful to my complete satisfaction.

\_\_\_\_\_  
Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist

\_\_\_\_\_  
Date