Patient Information

Date _____ Who can we thank for referring you:

Social Security Number _____ _____

Patient Name _____
Last Name First Name Middle Initial

Address _____

E-Mail _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____

Spouse's Name _____

Spouse's Employer _____ Occupation _____

Employer Address _____

Employer Phone # _____ Spouse's Cell Phone # _____

Spouse's SS# _____ Spouse's Birthdate _____

Dental Insurance

Who is responsible for this account? _____

Relationship to patient _____

Primary Insurance Co. _____

Subscriber's Name _____

Birthdate _____ Subscriber ID# _____ Group # _____

Secondary Insurance Co. _____

Subscriber's Name _____

Birthdate _____ Subscriber ID# _____ Group # _____

Relationship to patient _____

Insurance Assignment and Release

I certify that I, and/or my dependent, have dental insurance coverage with _____
Name of Insurance Company

and assign directly to Brooke M. Cloninger, D.D.S., Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature for all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance company and their agents to obtain payment for services or an estimate of payment for treatment. This consent ends one year from the date signed below.

_____ _____
Signature of patient/parent or guardian Date

Liability Waiver

I understand that Brooke M. Cloninger, D.D.S. does not accept DSHS, Medicaid, State, Provider One or Washington Apple Health at her private practice located at 2001 E. 29th Ave., Spokane, WA. Although Dr. Cloninger is a provider and is listed on the provider list, she only accepts these at the "IDEA" clinic which is located within the Riverstone Dental Clinic. I also understand that if I am a member of one of these plans, all dental treatment provided to me or my dependent(s) at Dr. Cloninger's private practice will not be billed to the plan and I will be financially responsible for the entire treatment amount.

_____ _____
Signature of patient Date

_____
Print Name

Health History

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with		Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
extractions or surgery	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tumor or growth on head	
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

_____ _____

Reviewed by Date

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐Latex _____

Dental History

Reason for today's visit _____

Former Dentist_____

City/State_____

Date of last dental visit _____

Date of last dental x-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Clicking or popping jaw	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
		Fingernail biting	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
		Food collection between the teeth	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
		Foreign objects	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
		Grinding teeth	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
		Gums swollen or tender	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
		Jaw pain or tiredness	☐ Yes ☐ No	Sores or growths in your mouth	☐ Yes ☐ No
		Lip or cheek biting	☐ Yes ☐ No	How often do you floss? _____	
		Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush?_____	

DENTAL INSURANCE POLICY

Brooke M. Cloninger, DDS proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create an estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated co-payments are due on or before the time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

I understand and agree to the Brooke M. Cloninger, DDS policy stated above. I authorize all my insurance companies to make payment directly to Brooke M. Cloninger, DDS. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

FINANCIAL OPTIONS

Brooke M. Cloninger, DDS will make every effort to simplify the out-of-pocket costs associated with your dental care needs. Your patient portion is due at the time of treatment. We gladly accept cash, check and all major credit cards as form of payment. We have a great relationship with two outside financial institutes, Care Credit and Lending Club.

In the event that your account has a balance that goes unpaid for more than 90 days, finance charges may be added at 18% of the amount due. We reserve the right to turn all unpaid accounts over 120 days to an outside collection agency.

I understand and agree:

Signature: _____ Date: _____

CANCELLATION POLICY

Brooke M. Cloninger, DDS makes an effort to see patients on time in order to give patients the care they deserve. Therefore, we ask that you **please give a 24 hour notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation or no-show fee of $55 per appointment hour for missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree:

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Brooke M. Cloninger, DDS's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____

Please list any person(s) with whom we may be able to discuss your dental/medical condition or treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____