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 extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ 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 or neck	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ 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?_____	

Brooke M. Cloninger, D.D.S.

Welcome to our office, and thank you for choosing us to care for your dental needs. Our entire team is dedicated to providing the highest quality dental care and service to our patients. Only the finest materials and techniques are utilized.

To provide a thorough and relaxing visit, we ask that you take a moment to review the enclosed materials. Feel free to ask any questions you may have. Our team will be happy to assist you in any manner possible.

Appointments
We value each patient's time and consider your appointment a commitment from our office to serve your needs in a timely and professional manner. Your appointment time is reserved exclusively for you. Absolutely no penalty will apply to scheduling changes made 24 hours in advance. Missed appointments, and short notice scheduling changes will affect the time we are able to offer to our patients who are in urgent need of our care. Changes made to scheduled appointments with less than 24 hours notice are subject to a $55 fee. We appreciate your participation and understanding. (Fee is subject to change at any time)

Financial Arrangements
Our goal with each of our patients is to provide a beautiful smile. So that there are no surprises, we are committed to communicating your specific treatment needs, as well as any related fees prior to scheduling. As a courtesy, we will keep any insurance information that you provide as part of our record of your care, and submit your claims accordingly. Please understand that your insurance benefits are a contract between you or your employer and the insurance company. Regardless of insurance coverage, each patient is responsible for any fees incurred. We ask that each patient have an understanding of their specific dental coverage. We welcome any questions you have and are committed to helping you make the most of your benefits.

Payment Options: Payment by the following is due at the time of service.

- Cash, Check
- Visa, MasterCard
- CareCredit or Capital One Financing

*There will be a $35 charge for all returned personal checks.

I understand and agree to comply with the above information.

Signature_____ Date_____

Grapetree Village ◦ 2001 E 29th Ave. ◦ Spokane, WA 99203
(509) 534-4600 ◦ Fax (509) 533-6334

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I_____, have received a copy of the office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices or acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

Consent to Release Information

Dr. Cloninger,

I _____ give permission for you or any member of your staff to discuss my dental/medical condition or treatment with the below named person/people.

_____

_____

_____
Relationship to Patient

Please do not discuss any personal dental or medical conditions or treatment with anyone other than those individuals listed above. This is in accordance with the HIPPA privacy laws.

_____
Patient Signature

_____
Date

It is my right to revoke this privacy right at any time. _____
Initial