# Cassity Implants

*"Advanced techniques for more comfortable care."*

South Ogden, UT 84403
5331 S Adams Ave. Suite A
**801-475-5577**

Kaysville, UT 84037
375 N. Main St, Suite 204
**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/#: _____

☐ MALE
☐ FEMALE
☐ MARRIED
☐ SINGLE
☐ DIVORCED
☐ WIDOWED
☐ MINOR

## EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone: (  ) - _____

**Whom may we thank for referring you?** _____

## RESPONSIBLE PARTY (if different from above)

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 Cassity & Legacy Implants & Periodontics 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:

| | |
|---|---|
| ☐ Cold or canker sores | ☐ Injury to face, jaw or teeth |
| ☐ Sensitivity to biting or pressure | ☐ Clenching or grinding teeth |
| ☐ Sensitivity to hot, cold or sweets | ☐ Periodontal (gum) treatment |
| ☐ Food trapped between teeth | ☐ Orthodontic treatment (braces) |
| ☐ Pain, clicking or popping of jaw | ☐ Chronic Snoring |
| ☐ Frequent headaches | ☐ Frequent day time sleepiness |

**MEDICAL INFORMATION**

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

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| AIDS or immunosuppressive disorder | ☐ | ☐ | Hepatitis, jaundice or liver disease | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Kidney trouble | ☐ | ☐ |
| Artificial joints | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Asthma or hay fever | ☐ | ☐ | Pacemaker | ☐ | ☐ |
| Cancer | ☐ | ☐ | Persistent cough | ☐ | ☐ |
| Cardiovascular disease | ☐ | ☐ | Sinus trouble | ☐ | ☐ |
| Cardiac pacemaker | ☐ | ☐ | Stomach ulcers | ☐ | ☐ |
| Damaged or artificial heart valves | ☐ | ☐ | Thyroid | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Tuberculosis | ☐ | ☐ |

**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