Lakeshore Family Dental Care, S.C.

Date: _____

Welcome to Our Practice

Patient Name: _____

How do you prefer to be addressed? _____

Address: _____
Street Address City, St. Zip

Telephone: Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Where and when is the best time to reach you? _____ Email Address: _____

Date of Birth: _____/_____/_____ **SS#:** _____-_____-_____
Mo. Day Yr.

(check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer: _____

Occupation: _____ There for _____yrs.

Employer Address: _____

Who may we thank for referring you? _____

Other family members seen by us? _____

Spouse's Name: _____

Date of Birth: _____/_____/_____ **SS#:** _____-_____-_____
Mo. Day Yr.

Telephone: Home: (_____)_____ Cell: (_____)_____

Employer: _____ There for _____yrs.

Employer Address: _____

Account Information (for insurance and payment purposes)

Dental Insurance Company: _____

Policy Holder's Name: _____ Group #: _____ Member ID#: _____

Secondary Insurance Company: _____

Policy Holder's Name: _____ Group #: _____ Member ID#: _____

Payment Plan Preferred:

☐ Cash or personal check at time of treatment.

☐ MasterCard, Visa or Discover at time of treatment.

☐ Care Credit at time of treatment.

Answers to the following questions are for our records only and will be considered confidential

My current medical health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you under the care of a physician? ☐ YES ☐ NO

Physician Name: _____ Office Telephone: _____

Office Location: _____

1. When was your last dental visit? _____ Current xrays? _____
2. Are you having pain or discomfort at this time? _____
3. Do you feel nervous about dental treatment? _____
4. Is there anything you dislike about your smile? _____
5. Have you been a patient in the hospital during the past two years? _____
6. Have you ever had any excessive bleeding requiring special treatment? _____
7. Are you taking any vitamins, herbal supplements? _____
8. Have you taken any medication or drugs in the past two years? _____

List all medications you take (prescription and over the counter) _____

_____

_____

Allergies: Are you allergic or have you had difficulty with any of the following substances?

☐ Penicillin ☐ Tetracycline ☐ Latex ☐ Aspirin ☐ Codeine ☐ Dental Anesthetic

☐ Sulfa ☐ Erythromycin ☐ Other _____

Have you ever had any of the following:

☐ Alcoholism	☐ Diabetes (Type I__ II__)	☐ Hemophilia/Bleeding	☐ Shingles
☐ Anemia	☐ Difficulty Breathing	☐ Hepatitis	☐ Sickle Cell Disease
☐ *Any type of transplant	☐ Drug Addiction	☐ Herpes /Cold Sores	☐ Sinus trouble
☐ Arthritis	☐ Eating Disorder	☐ High/Low Blood Pressure	☐ Steroid Treatment
☐*Artificial Joints	☐ Emphysema	☐ HIV Positive, AIDS	☐ Stroke
☐ *Artificial Valve	☐ Epilepsy /Seizures	☐ Kidney Problems	☐ Thyroid Disease
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Tobacco Use
☐ Auto Immune Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Blood Transfusion	☐ Headaches-severe/frequent	☐ Pacemaker/Defibrillator	☐ Ulcers
☐ Cancer	☐ Heart Failure	☐ Parkinson's Disease	☐ Venereal Disease
☐ Chemotherapy	☐ Heart Attack	☐ Psychiatric Treatment	
☐ Colitis	☐ Heart Murmur	☐ Radiation Therapy	
☐ *Congenital Heart Problems	☐ Heart Surgery	☐ Rheumatic Fever	
		☐ Scarlet Fever	

***Antibiotic pre-medication may be required prior to your appointment.**

Hospitalized for _____

Female Patients: ☐ Pregnant ☐ Nursing ☐ Using Birth Control _____ (type)

Do you exercise regularly? ☐ YES ☐ NO

If YES, what do you enjoy doing _____

The information I have provided is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNED: _____ **Dated:** _____

Lakeshore Family Dental Care Treatment Consent Form

I hereby consent to and authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I authorize the use of such local anesthesia, antibiotics, analgesia or any other type of drug as the dentist may consider advisable in my case and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (allergic reactions), cardiac arrest and aspiration, irritation and swelling of a vein, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I realize that in spite of the possible complications and risks my contemplated treatment is necessary and desired by me.

I have provided as accurate and complete a medical and personal history as possible, including those antibiotics, drugs, medications and foods to which I am allergic. **I will follow all instructions as explained and directed to me and permit prescribed diagnostic procedures.**

I understand that I am responsible for all costs of my (or my child's) dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

Patient Name: _____
(Print)

Signature: _____ Date: _____
(Patient or Parent/Guardian)

Lakeshore Family Dental Care

Authorization for Communication of Protected Health Information

It is frequently necessary for personnel at this practice to communicate appointment instructions, information about treatment, payment and other items of protected health information with our patients. It is frequently not possible to speak personally with our patient to leave this information. If our personnel are not able to speak with you (our Patient) directly, please give us instructions about communicating it to you, and who we are allowed to speak with on your behalf.

1. Messages may be left on my home answering device at: _____
2. My home answering device does not identify me by name, but it is appropriate to leave messages for me there. Yes_____ No_____
3. Messages may be left for me on my cell phone voicemail at: _____
4. Can you be called at work? Yes____ No____ (Phone:) _____
5. Messages may be left for me on my work voicemail at: _____
6. Messages may be communicated by texting on my cell phone at: _____
7. Messages may be left for me with my spouse (name:) _____
8. Messages may be communicated to me via email at: _____
9. Other person (s) authorized to receive messages and speak to us on my behalf:

Person #1: _____ Phone#: _____

Person #2: _____ Phone#: _____

Person #3: _____ Phone#: _____

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information. I understand that I may revoke this consent in writing at any time. This consent is valid from the date of signature unless otherwise revoked in writing.

_____

Patient Name (Print) **Date of Birth**

_____

Signature of Patient or Parent/Guardian **Date**

Lakeshore Family Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

_____, have received a copy of this 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, but acknowledgement could not be obtained because:

Individual refused to sign.

Communications barriers prohibited obtaining the acknowledgement.

An emergency situation prevented us from obtaining acknowledgement.

Other (Please specify)

_____

_____

_____

Lakeshore Family Dental Care Appointment and Financial Policy

The following is a statement of our financial policy, which we require you read, agree to and sign.

- Payment in full is due at time of service. Cash, check, debit card, mastercard, visa, discover and care credit are accepted.

- For patients with insurance, we will accept payment directly from most insurance companies but require that the deductible and non-covered fees be paid at each time of service.

- We will be happy to submit your dental insurance claims for you but please keep in mind that the insurance contract is between you and your insurance company. We will provide an insurance estimate to you, however understand it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequencies, age restrictions, downgrades, deductibles and maximums which are your responsibility. If you would like a more accurate insurance estimate, please ask us to submit a pre-estimate a head of your planned treatment.

- If you have any changes to your insurance, you must notify us at least 2 business days prior to your appointment. This allows us to prepare for changes in coverage prior to your visit that may affect your payment due. We can not guarantee same day insurance verification. If that is the case, full payment will be due at the time of your visit. Once the insurance payment has been received, you will be reimbursed any money due.

- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected.

- For your convenience, we provide patients with the option to authorize the use of their credit card. These authorizations allow us to charge a patient's credit card for unpaid copays or account balances in our office without your presence but only after your consent.

- **Minors accompanied by the parent or legal guardian:** The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at the time of service. **Unaccompanied minors**: The parent or legal guardian is responsible for full payment at the time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment.

- Cancellations & missed appointments: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24-hour notice for cancellations or for rescheduling your appointment. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A $50 fee may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments result in requiring pre-payment prior to scheduling.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to finance charges of 1.5% per month and late charges may apply.

I acknowledge I have received and agreed to Lakeshore Family Dental Care's payment and financial policies.

Patient name: _____ Date: _____

Patient/guardian signature: _____