

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone (_____) _____ Alt. Phone (_____) _____
Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (_____) _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (_____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone (_____) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (_____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Birthdate _____ Relation to Patient _____
Address (If different from patient's) _____ Phone (_____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (_____) _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____



Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- Bad breath
- Grinding teeth
- Sensitivity to hot
- Bleeding gums
- Loose teeth or broken fillings
- Sensitivity to sweets
- Clicking or popping jaw
- Periodontal treatment
- Sensitivity when biting
- Food collection between teeth
- Sensitivity to cold
- Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____



Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

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

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- Anemia
- Cortisone Treatments
- Hepatitis
- Scarlet Fever
- Arthritis, Rheumatism
- Cough, Persistent
- High Blood Pressure
- Shortness of Breath
- Artificial Heart Valves
- Cough up Blood
- HIV/AIDS
- Skin Rash
- Artificial Joints
- Diabetes
- Jaw Pain
- Stroke
- Asthma
- Epilepsy
- Kidney Disease
- Swelling of Feet or Ankles
- Back Problems
- Fainting
- Liver Disease
- Thyroid Problems
- Blood Disease
- Glaucoma
- Mitral Valve Prolapse
- Tobacco Habit
- Cancer
- Headaches
- Pacemaker
- Tonsillitis
- Chemical Dependency
- Heart Murmur
- Radiation Treatment
- Tuberculosis
- Chemotherapy
- Heart Problems
- Respiratory Disease
- Ulcer
- Circulatory Problems
- Hemophilia
- Rheumatic Fever
- Venereal Disease

MEDICATIONS: List medications you are currently taking:

ALLERGIES



Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)

Dr. _____ 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 on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

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

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

FINANCIAL AGREEMENT FOR LAKEWOOD DENTISTRY

I acknowledge that payment is due at time of treatment unless other arrangements are made. I agree that parents, guardians, or other representatives are responsible for all fees and services are rendered for treatment of a minor/child. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of charges. Insurance co pays are required at time of treatment. We offer monthly payment plans through Care-Credit, an independent credit source not affiliated with Lakewood Dentistry. (Approval is based on credit score.)

We expect a 24 HOUR notice on appointment cancellations, for all appointments. IF YOU FAIL TO GIVE A 24 HOUR NOTICE A \$30.00 FEE WILL BE ADDED TO YOUR ACCOUNT.

Signature of Patient, Guardian, or Personal Representative

Date