# Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely. If you have any questions or need assistance , please ask us- we will be happy to help.

## Patient Information

Name_____Nickname_____ Date of Birth _____Sex_____

Address_____City, State, Zip_____

Home Phone_____Work Phone_____Cell_____

E-Mail_____

Check Appropriate box: Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Other ( )

Preferred method of contact: Home Phone ( ) Work Phone ( ) Cell phone ( ) Text ( ) E-mail ( )

## Responsible Party Information

Name of Responsible Party(Guardian)_____Social Security #_____

Address (if different than patient)_____City, State, Zip_____

Occupation_____Employer_____

Employer's Address_____Phone_____

## Dental Insurance Information

Insurance Company_____Insured Name_____

Insured DOB_____Relationship to Patient_____

Subscriber #_____Group #_____Employer_____

Insurance Co Address_____Phone_____

## Secondary Dental Insurance Information

Insurance Company_____Insured Name_____

Insured DOB_____Relationship to Patient_____

Subscriber #_____Group #_____Employer_____

Insurance Co Address_____Phone_____

# *Patient Medical History*

General Health: Good ( ) Fair ( ) Poor ( )

Physician_____Office Phone_____Date of last Exam_____

Are you currently on any prescription or over the counter medications, vitamins, nutritional or herbal supplements? Y( ) N ( )
If "yes" Please list medications and purpose:

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes ( ) No ( ) If "Yes" please circle or list

Penicillin Codeine Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives Iodine Aspirin Any Metals

_____ _____

Please mark the ones that apply to you and your Medical History.

( ) Need antibiotic coverage prior to dental work?
( ) Artificial joint replacement or implant?
( ) Undergone Radiation or IV Chemotherapy?
( ) Use or have used tobacco products?
( ) Subject to prolonged bleeding?
( ) Family history of Diabetes?
( ) Excessive thirst and/or urination?
( ) Recent unusual weight loss?
( ) Subject to fainting?
( ) Recently hospitalized or past major surgeries?
( ) Currently pregnant?____How Far____
( ) Currently nursing?_____

**Please circle Y or N for each question:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | High Blood Pressure | Y | N | Heart Disease | Y | N | Osteoporosis |
| Y | N | Heart Attack | Y | N | Cardio Pacemaker | Y | N | Chest Pains |
| Y | N | Rheumatic Fever | Y | N | Heart Murmur | Y | N | Long-term Steroid Treatment |
| Y | N | Swollen Ankles | Y | N | Artificial Heart Valve | Y | N | Scarlet Fever |
| Y | N | Fainting/Seizures | Y | N | Frequently Tired | Y | N | Tuberculosis |
| Y | N | Asthma | Y | N | Anemia | Y | N | Glaucoma |
| Y | N | Epilepsy / Convulsions | Y | N | Emphysema | Y | N | Liver Disease |
| Y | N | Leukemia | Y | N | Cancer (type_____) | Y | N | Hemophilia |
| Y | N | Diabetes (type____)(A1C_____) | Y | N | Arthritis / Rheumatism | Y | N | Respiratory Problems |
| Y | N | Kidney Disease | Y | N | Jaundice / Hepatitis (type___) | Y | N | Mitral Valve Prolapse |
| Y | N | AIDS / HIV Infection | Y | N | Sexually Transmitted Disease | Y | N | Eating Disorders |
| Y | N | Thyroid Problem | Y | N | Stomach Trouble / Ulcers | Y | N | Neck or Back Problems |

Do you have any other medical or health conditions which is not listed? Yes ( ) No ( ) if "Yes" please list

_____

I certify that the answers given are correct to the best of my knowledge.

Signature_____Date_____Staff_____

## Emergency Contact

Name of relative or Person NOT LIVING with you_____Relationship_____

Phone_____Address_____

## Dental History

Name of Previous Dentist_____Last Visit_____Reason for today's visit_____

Have you ever had a serious problem associated with a dental treatment? Yes ( ) No ( )

If "Yes" explain_____

How often do you brush?_____How often do you floss?_____How often do you get cleanings?_____

What Dental aids do you use? Floss ( ) Toothpick ( ) Water Pick ( ) Electric Toothbrush ( ) Other ( )_____

Please answer "Yes" or "No"

| | | | | | |
|---|---|---|---|---|---|
| Are you hesitant to come to a dentist? | Yes ( ) | No ( ) | Do you snore or have trouble sleeping? | Yes ( ) | No ( ) |
| Do your gums bleed during brushing or flossing? | Yes ( ) | No ( ) | Would you like to have a whiter smile? | Yes ( ) | No ( ) |
| Do you have a bad taste or odor in your mouth? | Yes ( ) | No ( ) | Would you like to have straighter teeth | Yes ( ) | No ( ) |
| Does food frequently get caught in your teeth? | Yes ( ) | No ( ) | Do you have missing teeth you want replaced? | Yes ( ) | No ( ) |
| Do you have dental fillings you don't like? | Yes ( ) | No ( ) | Do you have loose dentures or partials? | Yes ( ) | No ( ) |
| Do you believe in the benefits of fluoride? | Yes ( ) | No ( ) | Do you grind your teeth? | Yes ( ) | No ( ) |

What do you NOT like about your smile?_____

What can we do to make your smile look better?_____

## Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize *Lyndon Family Dental* to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

*Insurance Release*: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier.

*Responsibility for Payment*: In the event that this matter is turned over to a collection agency or attorney for collection of any fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or bot a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection sums due and unpaid for the work herein set forth.

Signature_____Date_____

## Children or Minors

Because (name of child)_____ is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

Signature_____Date_____

# Authorization for Signature on File

## Release of Information / Financial Responsibility / Authorization for Payment

I (name of patient)_____ and/or (name of insured)_____

hereby authorize *Lyndon Family Dental* to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with (name of employer)_____

I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

To the extent permitted under applicable law, I authorize release of any information relating to my claim.

Signature of Patient (parent or guardian if minor)_____

Signature of Insured_____Date_____

This "Authorization" will be valid from this date and shall expire in one year. Expiration Date_____

A photocopy of this document may act as an original.

# Office Policy

## Financial Policy

Thank you for choosing Lyndon Family Dental to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is a part of your treatment. In the interest of good dental care practice, it is desirable to establish a policy to avoid any misunderstandings.

> On your first visit we expect you to supply our office with a picture ID (Drivers license, Pass Port, etc.). Also on your first and all subsequent visits you must present an ACTIVE DENTAL insurance card. Failure to present this information may result in rescheduling. If any change in insurance coverage should occur during the time you are a patient, it is YOUR responsibility to inform our office. If an insurance card submitted for services rendered has knowingly been terminated or lapsed you will be given ONE opportunity to pay for the services rendered before the issue is referred elsewhere.

> Patients are required to pay their deductible and co-payments at the time of each visit. Payments may be made with CASH, MAJOR CREDIT CARD OR PERSONAL CHECK. If paying with a personal check and the payment is returned for insufficient funds there will be an additional thirty ($30.00) fee added to the amount owed. You will be notified immediately, by phone and given an opportunity to settle the balanced owed before the issue is referred elsewhere.

> Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you pay your portion of the bill at the time of service. If we are unable to estimate your portion of the service due at the time of your appointment you will receive a statement for the outstanding balance not covered by your insurance. This balance will be DUE at time of receipt. We cannot accept responsibility for collecting a disputed claim or a claim that the insurance carrier is waiting on information from the insured before paying. Insurance policies are a contract between you, your employer and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.

> **Thirty (30) days after the initial billing, interest will begin accruing at the rate of 1.5% per month compounded, retroactive to the initial billing date.** If no payment has been received on an account after two attempts you will receive a third statement indicating that ***"This will be the final notice for payment".*** Lastly, we will make every effort to contact the responsible party. If the responsible party fails to contact our office, in a timely manner, after receiving such notice, the account will be sent to a collection agency.

## Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that you give us twenty-four (24) hours notice for cancellations; otherwise, we reserve the right to charge a minimum of $50.00 per half hour, based on the time that was reserved for your respective appointment. The length of time reserved and number of prior failed appointments will be utilized to compute your charge. We will no longer offer appointments to patients who continually fail to show for their appointments without having given proper and legitimate notice.

We encourage you to carefully and completely read this policy before signing.

_____ _____

Name (Please Print) Date

_____

Signature

## Estimates and Fees

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pupal therapy or cracked teeth could alter an estimate fee. It is customary to pay for dental services when rendered. There is a service charge on all unpaid accounts.

## Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency

## Notice of Privacy Practices (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. Of the uses and disclosures we may make of your protected health information. We encourage you to read it carefully and completely before signing this Consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.