

PATIENT INFO.

DATE _____

Mr. Mrs. Ms. Miss Dr.

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Child Single Married Other Male Female

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Nearest Relative not in your home _____ Phone # _____

Patient Employer or School _____ Occupation: _____

Drivers License # _____

E-mail Address: _____

Who Referred You? Phone Book Newspaper Sign Postcard Friend Name: _____

Internet surfing, which website: _____

DENTAL HISTORY

Have you been having any specific problems? Yes No Describe: _____

Last dental visit? _____ Purpose: _____ Last complete exam: _____

Has fear of discomfort kept you from regular visits? Yes No

How do you describe your dental health? Good Fair Poor

Do you feel you have active dental disease? Decay? Yes No Gum Disease? Yes No

Home Care: Brush? Yes No Floss? Yes No Water Jet? Yes No Other: _____

Do your gums ever bleed? Yes No How often? _____

What would you like to change the most in the appearance of your teeth? _____

Are your teeth all in alignment (straight)? _____

Do you have spaces that you don't like? _____

Do you like the color of your teeth? _____

Do you like the shape of your teeth? _____

Are there old fillings or dental work you don't like looking at? _____

How would you like your teeth to look? _____

Would you like information regarding our Bleaching Special? Yes No

Are you interested in straightening your teeth without braces? Yes No

MEDICAL HISTORY Please answer each question and mark yes or no where indicated.

Name of your Physician: _____ If you do not have a physician, please write "none".

Phone Number: _____ (Please call us back w/ phone number) Last Exam: _____

(Women) Are you pregnant? Yes No Expected delivery date _____ Are you taking birth control? Yes No

Are you under a doctor's care now? Yes No If so, for what reason? _____

Are you taking any pills, medications, or drugs? Yes No Please list: _____

Do you have or have you ever been treated for any of the following? **Please check all that apply.**

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Radiation/Chemo Treatment |
| <input type="checkbox"/> Allergy to medications | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hormone Replacement Tx | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergy (anesthetic) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy (other) _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Angina/Chest Pains | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anti-Depression Treatment | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis (Type) _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Aspirin Tx/Blood Thinner | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcer |

Do you use any type of tobacco product? None Cigarettes Cigar Pipe
 Have you used any street/illicit drugs in the past? Y N List: _____
 Currently use street/illicit drugs? Y N List: _____

To the best of my knowledge, all of the above dental and medical history answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail. _____

Responsible Party or Primary Insurance Information: Please notify front desk if there is secondary dental insurance.

Relationship to Patient: Self Spouse Parent

Responsible Party's name or Policy Holder's name _____

Social Security #: _____ Drivers License # _____

Date of Birth: _____

Address: _____ Single Married Other _____

City: _____ State: _____ ZIP: _____ Male Female

Home Phone: _____ **Work Phone:** _____ **Cell Phone** _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ ZIP: _____

Insurance Company Name: _____ Insurance Group No. _____

Insurance Plan Phone: _____ Effective Date: _____

Insurance Plan Address: _____ City: _____ State: _____ ZIP: _____

Secondary Dental Insurance _____

Insurance Group No: _____ Insurance Plan Phone: _____

Insurance Plan Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: Self Spouse Parent

Responsible Party's name or Policy Holder's name _____

Social Security #: _____ **Date of Birth:** _____

Payment Policies

- ▶ Fees are determined by the services required. You may discuss any fees with our Office Staff.
- ▶ **All estimated co-pays and deductibles are due at the time of service.**
- ▶ Your account, if any balance is due after insurance pays, is **due by the 30th** of the month. **A \$5.00 late fee will incur if received 3 days late**, as well a finance charge to any past due accounts.

Payment Options:

For Crowns ▶ Payment of One-Half Down at the First Appointment and the Balance at Cementation. For Bridges, Dentures and Partial ▶ Payment of One-Half Down at the First Appointment and the Balance at try-in visit.

▶ **Six Months Same as Cash: Through Care Credit for our patients who qualify. Extended payment plans are available (not interest free). (If interested ask for an application.)**

- **Due at the time of service:** All co-payments will be collected at the time of service.
- **We accept cash, checks (ran thru Telecheck with a valid license), credit and debit cards.**

Collections Policy

If a collection agency is used to recover any unpaid balance due to us, **the responsible party is liable for all charges** incurred. **You will be charged \$25.00 for a returned check with insufficient funds. \$10.00 for each time check is re-processed.**

APPOINTMENT CANCELLATION POLICY/BROKEN APPOINTMENTS/OR *LATE FOR APPOINTMENTS/DISMISSAL OF PATIENT

Your appointment has been reserved exclusively for you. Please provide ample notification if you need to change your appointment. Your appointment time may be appreciated by another patient. **Failure to give 24 hours notice will result in a charge of \$45.00/per hour of scheduled time. *You will be charged \$45.00 and rescheduled if you are 15 minutes late. PLEASE RESPECT OUR TIME AND THE PATIENTS SCHEDULED AFTER YOU. You will be dismissed as a patient if you consistently break appointments or consistently arrive late for appointments.**

Consent for Services

After my exam, I authorize the doctor to perform the necessary treatment as needed. Any major treatment ie; root canals, oral surgery, implants will be discussed and an additional consent will be signed. I authorize the release of any information relating to dental treatment to third party payers and/or other health practitioners for myself or my dependents by Lakeland Hills Dental. I authorize my doctor to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for my dependents or myself. **I understand that all insurance payments will be made directly to the doctor, unless otherwise specified by me.**

Records and X-rays

Illinois Dental Practice Act(225 ILCS 25/50). Every dentist shall make a record of all dental work performed for each patient. The record shall be made in a manner and in sufficient detail that it may be used for identification purposes. Dental records required by this section shall be maintained for 10 years. Dental records required to be maintained under this section, or copies of those dental records, shall be made available upon request to the patient or the patient’s guardian, provided that the reasonable cost of reproducing the records has been paid by the patient or the patients guardian.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENTS.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN:_____ DATE:_____