EAST LAKE DENTAL

It is our goal to provide you with high quality care, assuring you long-term health and comfort

ABOUT YOU

Today's Date:_____

Email Address:_____

Name_____
LAST FIRST MI MR MRS MS DR

I prefer to be called:_____ Male Female

Birth date:___/___/___ Age:___ SS#_____

Home Address:

_____
APT/CONDO #

_____
CITY STATE ZIP

Single Married Divorced Widowed Separated

Home # (___)_____ Pager/Cell #_____

Work # (___)_____ Ext___ DL#_____

Employer_____

Occupation_____

Person Responsible for Account:_____

Whom may we thank for referring you?_____

Previous/Present dentist:_____

Last visit date_____

SPOUSE INFORMATION

HIS/HER Name:_____

Employer_____

Phone #_____ Birth date:___/___/___

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name:_____ Relation:_____

Work # (___)_____ Home # (___)_____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local, or Policy #)_____

Insured's Name:_____ Relationship:_____

Insured's Birth date:___/___/___ Insured's SS#_____

Insured's Employer:_____

Secondary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local, or Policy #)_____

Insured's Name:_____ Relationship:_____

Insured's Birth date:___/___/___ Insured's SS#_____

Insured's Employer:_____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name:_____

Work # (___)_____

Date of last visit:_____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please Explain:_____

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one:_____

Do you smoke or use tobacco in any other form? Yes No

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #_____

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Sever/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Trait
Y N Sinus problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Y N Anemia/Radiation Treatment
Y N Artificial Bones/ Joint/Valves
Y N Arthritis
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty breathing
Y N Drug/Alcohol abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/ Fainting Spells
Y N Fever blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker

Please list any serious medical condition(s) or artificial replacements that you have ever had :

_____
_____
_____
_____

Are you allergic to any of the following?

Y N Asprin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/material that you are allergic to:_____

_____
_____
_____

Dental History

Why have you come to the dentist today?

_____
_____
_____

Do you require antibiotics before dental treatment? Y N

Are you currently in pain? Y N

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Do you now or have you ever experienced pain/discomfort your jaw joint (TMJ/TMD)? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss?_____
How many times a day do you brush?_____

Type of bristles? Hard Medium Soft

Have you ever taken Phen-Fen? Y N
(also known as Redux or Pondimin)

If so, when?_____

I understand that the information that I have given today is correct t the best of my knowledge. I also understand that this information w be held in the strictest confidence and it is my responsibility to infor this office of any changes in my medical status. I authorize the den staff to perform any necessary dental services that I may need durin diagnosis and treatment with my informed consent.

_____
Signature Date

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

Thank you for filling out this form completely. It will enable us to you more effectively. If you have any questions at any time, please us. We are happy to help.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials_____ Date:_____

Doctor's comments:_____

MEDICAL HISTORY UPDATE

1. Date:_____ Comments:_____ Signature:_____
1. Date:_____ Comments:_____ Signature:_____
1. Date:_____ Comments:_____ Signature:_____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ]_____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

Email address _____

Patient Financial Policy

Welcome to our office. We are honored that you have chosen us as your dental healthcare provider. We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits.

1. Payment is due at time of services are rendered unless payment arrangements have been approved in advanced by our accountant. We accept payment for services in cash, checks, and credit cards.
2. If you have dental insurance we will be happy to file it for you and estimate your benefits to the best of our abilities.
3. Fees quoted are accepted for 90 days. In event that clinical conditions warrant a different treatment, you will be notified of the changes in fees prior to proceeding with the procedure.
4. Balance older than 60 days will be subject to interest charges of 1.5 % per month, 18 % annually.
5. A $50.00 No Show Fee will be charged for any appointment canceled less than 24 hour notice.

Insurance

The process of utilization and quality of insurance has changed much over the years. The amount of coverage your insurance provides is strictly a function of the policy selected by you and your employer. We will be happy to file your claim forms for you and we will accept assignment of insurance benefits on primary coverage. Not all services are a covered benefit in all contracts. Please supply our staff with complete insurance information. Our staff will estimate your co-pay and deductible. You can verify your co-pay and deductable by going to your insurance website. This amount will be due at time of services. The amount the insurance company pays varies greatly. If they pay more than expected we will either refund you or carry the amount as a credit. If they pay less, we will send you a statement with the balance. We request payment in full in 14 days.

Note: <u>You are responsible for knowing your insurance. Your insurance is a contract between you, your employer and the insurance carrier</u>. We are not a party to that contract. If you have a problem with your insurance coverage, we ask that you speak directly to your insurance company. Your charges in our office are your responsibility from the date of service. We do not base your diagnosed treatment on your insurance coverage. We base it on your needs and desires. We take pride in the quality care we offer our patients and make every effort to have your dental visits with us be as comfortable as possible.

Thank you for reviewing our financial policy. We make every effort to explain your costs to you and to avoid misunderstandings so that we can focus on your dental health. Pleases let us know if you have any questions or concerns. We are here to serve you.

I have read, understand and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Signature: _____ Date: _____

East Lake Dental PLLC

(NAME OF PRACTICE)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Patient Name Relationship to patient

_____
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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____