Lake Forest Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have any 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 (____) _____ Cell Phone (____) _____
Name: _____ SS#: _____
Address: _____ E-mail: _____
City: _____ State: _____ Zip: _____
Sex: ___M ____F Age: _____ Birthdate: _____
___Married ___Widowed ___Single ___Minor ___Separated ___Divorced
Whom may we thank for referring you? _____
Emergency Contact/ Name and Phone Number: _____

Primary Insurance

Person Responsible for Account: _____
Relation to Patient: _____ Birthdate: _____ SS#: _____
Address (if different from patient's): _____
Phone: (___)_____ City: _____ State: _____ Zip: _____
Person Responsible Employed by:_____ Occupation:_____
Business Address:_____ Business Phone: (___)_____
Insurance Company: _____ Dental/Member Services Number:_____
Subscriber #: _____ Group #: _____
Names of other dependents 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 any of the following: ___Bad breath ____Grinding
___Sensitivity to heat ___Bleeding Gum ___Loose teeth or broken fillings
___Sensitivity to sweets ___Clicking or Popping ___Periodontal treatment
___Sensitivity when biting ___Food collection between teeth ___Sensitivity to cold
___Sores or growth 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 taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, 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 date: _____
(WOMEN) Are you pregnant? ____Yes ____No Nursing? ____ Yes ____ No
Taking birth control pills? ____Yes ____No

Please circle if you have or have had any of the following:

Anemia	**Cortisone Treatment**	**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/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**

Other: _____

What medications are you taking? _____
What medications are you allergic to? _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign direction to 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-names 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.

I certify that the information above is correct and complete.

_____ _____
Signature of patient, guardian or personal representative Date

_____ _____
Please print name of patient, parent, guardian or personal representative. Relationship to patient

Lake Forest Dental Clinic P.A.
Family & Cosmetic Dentistry

TO ALL OUR PATIENTS

IN EFFORT TO KEEP DENTAL COSTS DOWN WHILE MAITAINING A HIGH LEVEL OF PROFESSIONAL CARE, WE HAVE ESTABLISHED THE FOLLOWING INFORMED CONSENT FOR OUR PATIENTS.
WE ENCOURAGE OUR PATIENTS TO DISCUSS ANY QUESTIONS THEY MAY HAVE REGARDING OUR POLICES.

FINANCIAL POLICY:

1) Payment in **FULL** at the time of visit is due.
2) We accept cash, Care Credit and all major credit cards **ONLY.**
3) If you have dental insurance, which provides coverage for this provider, we will be happy to help determine the coverage you have available.
4) Keep in mind however: your insurance policy is a **contract between you and your insurance company. We, therefore, cannot guaranty payment of your claims or accept responsibility of negotiation with insurance companies or other persons.**
5) If your insurance has not paid or denied your claim in 45 days, you are responsible for full payment of all unpaid claims.
6) For any balances over 60 days, interest will accumulate at the rate of 1% per month.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SERVICE. FEES ARE SUBJECT TO CHANGE EVERY YEAR.

DELINQUENT ACCOUNTS will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees/ attorney's fees.

NO-SHOW AND CANCELLATION POLICY:
Your visit has been reserved for you and the dentist; a 48-hour notice is required in advance for cancellations in order to allow all our patients to receive the best possible dental care. There will be a fee if no notice is received.

I hereby authorize the release of any dental information necessary to process claims. I authorize the payment of benefits to the dentist described herein for services rendered.

STATEMENT OF UNDERSTANDING:
I HAVE READ AND UNDERSTAND THIS INFORMATION SHEET AND INFORMED CONSENT.

_____ _____
Patient Name Date of Birth

_____
Patient or Legal Guardian Name

_____ _____
Patient or Legal Guardian Signature Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

INFORMED CONSENT FOR DENTAL EXAM, X-RAYS, MEDICATIONS, CHANGES IN TREATMENT PLAN, PROPHYLAXIS, FLUORIDE TREATMENT, ANESTHESIA, & NITROUS OXIDE

PATIENT: _____ **DATE OF BIRTH:** _____

DENTAL EXAMINATION AND X-RAYS

- I understand that regular dental exams and x-rays are needed to complete the examination diagnosis and treatment plan. X-rays are an important diagnostic tool for the dentist. Many diseases of the teeth and surrounding tissues cannot be seen visually. An x-ray may reveal the presence of caries between the teeth, infections in the bone, abscesses, cysts, and other items which cannot be seen visually. Risks from radiation exposure have been significantly reduced by improvements in technology. I understand if I choose not to allow x-rays to be taken, the dentist cannot formulate an accurate diagnosis and treatment plan.

Initial_____

MEDICATIONS

- I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Initial_____

CHANGES IN TREATMENT PLAN

- I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination (the most common being root canal therapy following routine restorative procedures). I give my dentist permission to make any/all changes and additions as necessary.

Initial_____

PROPHYLAXIS (CLEANING) AND FLUORIDE TREATMENT

- Regular dental prophylaxis plays an important role in proper dental health. Prophylaxis includes removal of soft and hard deposits on teeth, and teeth polishing with prophy paste. Risks include, but not limited to, sensitivity or bleeding of the teeth or gums. Fluoride is applied topically as a gel or paste. Fluoride helps to prevent tooth caries by making teeth stronger and is considered safe when properly used. Ingestion of high concentration can lead to nausea and/or vomiting.

Initial_____

LOCAL ANESTHETICS

- I understand that the administration of local anesthetic may cause an adverse reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary, or rarely permanent, numbness. I understand that occasionally needles break and may require surgical removal.

Initial_____

NITROUS OXIDE (LAUGHING GAS)

- Nitrous oxide is a mild gas that is a mixed with oxygen and is used to sedate a person. It is administered through a mask placed over the nose. I elect to have nitrous oxide in conjunction with the dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are limited to, nausea, vomiting, dizziness, and headache. I understand that nitrous oxide is **not indicated if I am/might be pregnant** or have had ophthalmic surgery (retinal surgery) with medical specialty gas C3F8 (pefluoroprane-SF6 (sulfur hexafluoride).

Initial_____

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Patient's or Legal Guardian's Signature Date

_____ _____

Witness to Patient's Signature Date

I, Dr. _____, DMD certify that I have explained to the above patient the ramifications of the above treatment initialed by the patient to the best of my professional ability. I further certify that in my opinion, the above patient is fully informed of the risks and possible benefits of the particular procedure agreed upon.