Lakeview Dental, LLC
Center for Modern Dentistry

Patient Information

Name _____ , _____ Date of Birth _____
Last First

Address _____

_____ , _____ , _____
City State Zip

Home Phone _____ Cell _____ Preferred Contact: ☐ Cell ☐ Home

Email _____

☐ Female ☐ Male ☐ Minor ☐ Single ☐ Married ☐ Widow

Emergency Contact (Name & Phone) _____

How did you hear about us?

☐ Signage ☐ Flyer in Mail ☐ Google Map ☐ Other _____
☐ Web Search ☐ friend

Whom may we thank for referring you: _____

Insurance Information (leave blank if non-insured)

Are you the policy holder: ☐ Yes ☐ No

If you are not the policy holder, enter the policy holder's info below; otherwise enter your personal info

Policy Holder's Name (if not self) Last _____ First _____

Insurance Company _____ Employer_____

SSN _____ Date of Birth _____

Policy # _____ Group # _____

For my convenience, I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer. **I understand that I am responsible for all costs of dental treatment**. If I have dental insurance, deductibles and co-payments are due in full at the time of treatment and **I will be responsible for any amount that is not paid by my insurance as expected**. I further authorize direct payment of the dental benefits to this practice.

_____ _____
Signature of Patient/Legal Guardian Date

Health Information

Date of last dental visit: _____ Reason for this visit: _____

_____

Family Physician: _____ Office Phone _____ Last Exam Date _____

Medical:

Y	N		Y	N		Y	N	
☐	☐	Abnormal bleeding	☐	☐	Gastrointestinal disease			
☐	☐	Acid reflux	☐	☐	Glaucoma	☐	☐	Pacemaker
☐	☐	Anemia	☐	☐	Heart attack	☐	☐	Radiation Therapy
☐	☐	Angina	☐	☐	Hepatitis B, C	☐	☐	Seizures
☐	☐	Artificial heart valve	☐	☐	High blood pressure	☐	☐	Smoking
☐	☐	Asthma _____	☐	☐	HIV	☐	☐	Stroke
☐	☐	Cancer _____	☐	☐	Kidney problems	☐	☐	Substance abuse
☐	☐	Chemotherapy	☐	☐	Liver problems	☐	☐	Thyroid problems
☐	☐	Diabetes, Type I / Type II	☐	☐	Pregnancy, Week#_____	☐	☐	Tuberculosis
☐	☐	Eating disorder	☐	☐	Osteoporosis _____	☐	☐	Heart valve replacement
☐	☐	Fainting	☐	☐	Neurological disorder	☐	☐	Joint replacement
						☐	☐	Date of surgery : ____

Have you ever taken Bisphosphonates in the past (Fosamax, Boniva, Actenol, Zometa, Nerixia, etc)? ☐ **Yes** ☐ **No**

Allergy:

Y	N		Y	N	
☐	☐	Latex	☐	☐	Penicillin
☐	☐	Codein	☐	☐	Clindamycin

Other allergy: _____

Dental:

Y	N		Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Grinding/clenching	☐	☐	Sensitivity to cold / hot
☐	☐	Bleeding gums	☐	☐	Loose teeth	☐	☐	Frequent headache
☐	☐	Clicking of the jaw	☐	☐	Previous Gum surgery	☐	☐	Sensitivity to sweet

Authorization and Release

The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care.

_____ _____

Signature of Patient/Legal Guardian Date

Please list all medications currently taking:

Medication	Dosage	For what condition

Lakeview Dental, LLC Office & Financial Policy

Welcome to Lakeview Dental! *Please read our office and payment policy below:*

- You are responsible for notifying our office about change of address; phone number; or insurance plan.
- As a courtesy, we may confirm your appointment; however, you are ultimately responsible for keeping your scheduled appointment or, if necessary, cancelling it at least 24 hours in advance.
- We reserve the right to charge a fee for broken appointments without notice.
- We will be unable to reschedule an appointment if you have three(3) or more broken appointments.
- We accept cash and most major credit cards. We do not accept personal checks.

IF YOU DO NOT HAVE DENTAL INSURANCE

- It is your responsibility to pay the entire bill once treatment has been rendered or to inform us beforehand of your inability to pay so we may present to you available payment options for your dental treatment.
- Should legal action be instituted to enforce payment for services rendered, the signer(s) agrees to pay all court costs and/or reasonable attorney's fees incurred by the holder in such action.

IF YOU HAVE DENTAL INSURANCE

- As a courtesy, we will file your insurance claim for treatment rendered in our office.
- **We cannot guarantee payment from your insurance company** and your balance may be different than our estimate.
- **Regardless of what your insurance company pays or does not pay** toward your treatment you will be responsible for payment for your dental treatment.
- **You agree to pay your bill in full once treatment is rendered, if your insurance company had not paid or underpays for your treatment.** You understand that your insurance company may ask for additional information and we will provide this information upon request. If for any reason there is an overpayment on your account, a refund check will be sent to you.
- **You agree that we are not responsible for knowing the various scenarios in which your insurance company does not pay for services.** Such scenarios include pre-existing conditions, waiting periods, x-rays which can only be paid every so often, less costly alternatives, required pre-authorizations, etc. Your insurance can use any of these and other reasons to avoid paying your claim. We will try to provide you with as much information as possible; however, we will not be responsible for knowing the various details of your particular insurance plan.
- You must pay any balance on your bill not paid by your insurance company within 30 days of receiving a statement unless other payment arrangements have been made.

I have read, understood, and agreed to the above office and payment policy.

Patient's Name (print) _____, _____
Last *First*

PATIENT'S (or Legal Guardian) SIGNATURE: _____ Date _____

Health Insurance Portability and Accountability ACT (HIPAA)

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

I give permission to disclose details of my account, chart, and conditions to the following people. (The most frequently listed person is the spouse).

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____