PATIENT INFORMATION

Date:				New Patient	Update	
Patient:						
	Last	First	MI	Preferred	Title	
	Male Female	Child* Student**		Single Married Divorced Widowed		

*If Child, provide parent/guardian name(s) below:	**If Student, please complete: Fu
Parent/Guardian Name(s)	School/Location

Patient Date of Birth:		Patient SSN:			
Address:					
	Address Line 1				
				Cell:	
	Address Line 2			Work:	
				Other:	
	City	ST	ZIP Code		
E-Mail:					
Referral?	Yes No	Referred by:			

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

		Tel:	
Name	Relationship		

EMPLOYMENT INFORMATION

Employer:		Occupation:			
Address:					
	Address Line 1			Work:	X
				Direct:	
	Address Line 2			Other:	
				Pager:	
	City	ST	ZIP Code	Fax:	
E-Mail:					

INSURANCE INFORMATION

Subscriber:					
	Last	First	MI	Preferred	Title
Subscriber Date of Birth:		Subscriber SSN / ID #:			
Subscriber Employer:					
Patient Relationship to Subscriber:	Self Spouse Child Other				
Primary Insurance Carrier:					
Group/Policy		ID No.:			

No.:					
Address:				Tel:	
				Toll-free:	
				Fax:	
	City	ST	ZIP Code		

PREVIOUS DENTIST INFORMATION			
Dentist:		Telephone:	
Clinic/Facility:			
Address:			
	City	ST	ZIP Code
Reason for changing:			

DENTAL HISTORY			
Oral Health: Excellent Good Fair Poor			
Date of Last Dental Visit:		Treatment Type:	
Would you like to have an Oral ID cancer screening? YN			
**Note: Some insurance plans do not cover this service; please check your plan documents for details.*			

YN	Are you currently having dental discomfort? If yes, explain:	
YN	Any unhappy/unpleasant dental experiences? If yes, explain:	
YN	Any injuries to mouth/teeth/head? If yes, explain:	
YN	Any missing teeth other than wisdom teeth or orthodontic extractions?	
YN	Have missing teeth been replaced?	
YN	Orthodontic appliances now or in the past?	
YN	Gums bleed when brushing or flossing?	
YN	Concerned about gum disease? History of gum disease? YN	
YN	Any concerns about the appearance of your teeth?	
YN	Does it hurt to bite or chew?	
YN	Do you clench or grind your teeth? If so, do you wear a night guard or splint? YN	
YN	Do you want to become a regular continuing care patient in our practice?	
YN	Do you want your mouth properly restored and pain free?	
YN	Does any type of dental treatment make you nervous? If yes, please explain below:	

The most important concerns regarding my dental treatment are:		
What factors are most important for your satisfaction with our office?		
Any additional concerns/comments?		

Child/Minor Patients: Please answer the following questions:			
YN	Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)		
YN	Any unusual speech habits? If yes, explain:		
YN	Any lost teeth? If yes, list:		
YN	Does the patient receive assistance with brushing and flossing? If yes, how often?		

PRIMARY PHYSICIAN INFORMATION		
Patient Name:	Date:	
Physician:	Clinic/Facility:	Telephone:

MEDICAL HISTORY UPDATE			
General Health: Excellent Good Fair Poor			
YN	Under a physician's care now?		
YN	Any hospitalization in the past 5 years?		
YN	Any serious illnesses/surgeries?		
YN	Use tobacco in any form? If Yes, Type:		
YN	Is pre-medication required before dental visits due to heart condition or artificial joint?		
YN	Taking any prescription or daily OTC medications/drugs? *If yes, list details in the*		

	Medication Section.
YN	Do you snore?
YN	Have you ever been told you snore?
YN	Have you ever been diagnosed with Sleep Apnea?
YN	Do you ever wear a c-pap or any other device?
YN	Has anyone told you that you hold your breath while sleeping?

Female Patients:	YN Currently nursing?	YN Currently pregnant?	Due Date:	

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? YN
If yes, please describe:

Is there anything important about your medical condition we have not asked? YN If yes, please describe:

All Patients: Do you have, or have you ever had any of the following? (Check all that apply): None

Acid Reflux	Bulimia	Hearing Problems	Psychiatric Treatment
ADHD	Cancer/Malignancy	Heart Attack	Radiation/Chemo
AIDS/HIV	Cerebral Palsy	Heart Disease	Respiratory Disease
Anemia	Chemical Dependency	Heart Murmur	Rheumatic Fever
Anorexia	Chicken Pox	Hepatitis	Sinus Problems
Anxiety	Convulsions	High Blood Pressure	Stroke
Artificial Heart Valve	Depression	Kidney Disease	Thyroid Condition
Artificial Joints	Diabetes	Liver Problems	Tuberculosis
Arthritis	Dizziness/Fainting	Mitral Valve Prolapse	Ulcers
Asthma	Epilepsy/Seizures	Mononucleosis	Venereal Disease
Autism/Asperger's	Frequent Ear Infections	Pacemaker	
Bleeding Disorder	Frequent Headaches	Other – please list:	

All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply):

Aspirin	Codeine	Lactose Intolerance	Sleeping Pills	None
Anesthetic – Local	Dairy	Metal Sensitivity	Sulfa Drugs	
Barbiturates	Latex	Nitrous Oxide Sedation	Penicillin/Other Antibiotics	
Other – please list:				

MEDICATION INFORMATION

All Patients: Are you currently taking any of the following? (Check all that apply): None

Antibiotics/Sulfa Drugs	Antihistamines/Allergy	Daily Aspirin	Blood pressure Medications
Blood thinners	Cancer/Chemo Medications	Cortisone/Steroids	Heart Medication/Digitalis

Insulin	Nitroglycerin	Oral Contraceptives	Osteoporosis Medications
Other Diabetic Medications	Recreational Drugs	Thyroid Medications	Tranquilizers
Other (please list below)			

Patient Name:		**Date:**
Drug Name	**Dosage**	**Reason Prescribed**

Patient Signature:		Dentist Signature:	

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network for Delta Dental Premier.**

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case,

you would be responsible for the difference.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
    - All major credit cards are accepted (Visa, MasterCard, Discover)
    - Various financing options with CareCredit® and GreenSky

- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge unless prior financial arrangements have been made.**

Short Cancelled/ Missed Appointments

- **Please give 48-24 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

- **Short canceled or missed appointments** will be charged $25 per hour.

By signing below I acknowledge I have read and understand the guidelines above.

Signature:_________________________________ Date:__________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____**Date:**

Relationship to Patient: Adult Patient Parent Guardian Other

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Garden Lakes Family Dentistry **(please check all that apply)** :

Cell phone: Text Message reminders permitted
Home phone Work E-Mail:

I am granting permission Garden Lakes Family Dentistry to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for Garden Lakes Family Dentistry to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

Home Phone Cell Phone Work Phone None- please just ask for a call back
Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason: The patient refused to sign Communication barriers Emergency situation
Other – please list:

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Garden Lakes Family Dentistry of the dental benefits otherwise payable to me.

I hereby authorize Garden Lakes Family Dentistry to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: ____ Date: _______________________