LAKE DISTRICT FAMILY DENTISTRY

GUILLORY, CARLTON, RICHTER, & MANGUM

PATIENT

Title First Name M.I.	Last Name	Preferred Name	
Mailing Address	City/State		Zip
Home Phone ( )	Cell ( )	Other/Work ( )	
Date of Birth Male☐ Female☐	Employer		
Social Security #	Driver's License #		
Email	Family Physician		
Preference for Confirming Appointments: (circle one) Email☐Text☐Phone☐	Emergency Contact & Number		
How did you hear about us?	Dentist Preference		

PERSON RESPONSIBLE FOR FINANCIAL OBLIGATIONS (If different from above)

Name	Last Name	Relation to Patient	
Mailing Address	City/State		Zip
Home Phone ( )	Cell ( )	Other/Work ( )	
Date of Birth	Social Security #	Driver's License #	
Email	Do we have permission to contact you via Email, Text or Voicemail regarding your financial obligations? ☐ Yes ☐ No		

Primary Dental Insurance

Policy Holder's Name	Name of Insurance
ID Number/SSN	Policy/Group Number
Employer	Policy Holder's Date of Birth

Secondary Insurance

Policy Holder's Name	Name of Insurance
ID Number/SSN	Policy/Group Number
Employer	Policy Holder's Date of Birth

	Yes	No
1. Has it been over 1 year since your last dental appointment? If so, how long?	☐	☐
2. Do you have anxiety in the dental chair?	☐	☐
3. Are you happy with the color, shape, position of your teeth/ smile?	☐	☐
4. Are you here for a specific reason today? If so, what?	☐	☐

PATIENT MEDICAL HISTORY

Do you have or have you had any of the following? If not, please check "None of the Above."

✓

☐	Acid Reflux	☐	High Blood Pressure
☐	ADD/ADHD	☐	High Cholesterol
☐	Allergy to Latex	☐	History of Alcohol/ Drug Abuse
☐	Angina/ Chest Pain	☐	HIV, Hepatitis, other Contagious Disease
☐	Arthritis /Joint Disease	☐	Immune Issue/ Disorder
☐	Asthma	☐	Irregular Heart Beat
☐	Autism	☐	Joint Replacement (Hip, Knee, etc.)/ Date?
☐	Blood Disorder/ Anemia	☐	Liver Disease/ Problems
☐	Blood Thinner	☐	Low Blood Pressure
☐	Cancer/ What type?	☐	Mental or Physical Disability/ Specify:
☐	Cardiac Pacemaker	☐	Nervousness/ Anxiety
☐	Chronic Fatigue	☐	Night Sweats
☐	Clench/Grind Teeth/ When did this begin?	☐	Organ Surgery/ Loss of Major Organ Transplant
☐	Congenital Heart Disease/Defect*	☐	Osteoporosis/ Osteopenia
☐	Depression	☐	Parkinson's Disease
☐	Diabetes/ Low Blood Sugar	☐	Popping of Jaw/ Clicking of Jaw / When did this begin?
☐	Dialysis/ Kidney problem	☐	Pregnant Currently / Due date?
☐	Emphysema/ COPD/ Difficulty Breathing	☐	Prosthetic Heart Valve/ Shunt/ Stent/ Year placed?
☐	Epilepsy/Seizures	☐	Radiation or Chemotherapy
☐	Excessive Bleeding or Bruising	☐	Rheumatic Fever or Rheumatic Heart Disease*
☐	Fainting Spells / Dizziness	☐	Sinus Issues/ Surgery
☐	Glaucoma	☐	Sleep Apnea/ Are you treated?
☐	Hay Fever	☐	Snore
☐	Head Injury	☐	Stomach Ulcers/ Colitis
☐	Headaches/ How often?	☐	Stroke
☐	Heart Disease/ Heart Attack	☐	Temporomandibular Joint Disorders/ (TMJ)
☐	Heart Murmur or Prolapsed Valve	☐	Thyroid Issues
☐	Heart Shunt/ Stent	☐	Tuberculosis
☐	Heart Surgery/ Specifically for what?	☐	None of the Above

	YES	NO
1. Are you taking any medications? List Medication/ Reason/ Frequency:	☐	☐
2. Have you ever had any ALLERGIC / ADVERSE REACTIONS to anesthetics/ antibiotics/ medications? List:	☐	☐
3. Are you under the care of a physician for a current problem? If yes, explain:	☐	☐
4. Have you been hospitalized within the past 5 years? Please specify.	☐	☐
5. Is there any other condition concerning your health about which the doctor should be told? Specify:	☐	☐

Please Sign After Reading:

Charges for dental services are due at time of the service. Payment may be made with cash, check, Visa, MasterCard, AMEX or Debit cards, Care Credit or Lending Club. After 60 days, all balances will accrue a 1.5% financial charge.

I understand that I (or the guarantor listed) am ultimately responsible for any delinquent charges on this account (including those in association with the Practice, collections agencies and/or attorney's fees.)

Patients with Insurance: As a courtesy to our patients, this office will file and process my dental insurance claims for my convenience. There is never a guarantee that insurance will assist with payments and I understand that financial obligations are ultimately that of the patient. I understand that I am fully responsible for all financial obligations for services rendered at this office excluding any assistance provided by my insurance payments and am aware that if my insurance has not paid the doctor(s) within six (6) weeks from the date of service, I am responsible for paying the entire balance immediately.

I understand that the contract I hold with my Insurance Carrier is independent of Lake District Family Dentistry. I also understand that any fees expected/quoted to be paid by my insurance company are *only estimates.* I authorize payment of the dental benefits from my insurance to be payable to the doctor(s) of Lake District Family Dentistry.

Consent: It is necessary for us to have the consent of our patients or a parent/ legal guardian of minors. The signature below therefore authorizes the doctor to perform any and all forms of dental treatment, use dental products/ materials, and/or therapy that has been presented and agreed upon (includes written and/or verbal agreements). I understand that although rare, dental treatment has a risk of death, brain damage, quadriplegia, paraplegia, the loss of function or loss of an organ or limb, or disfiguring scars, and that I may ask questions concerning such dental treatment.

It is also necessary to have the consent of our patients or a parent/ legal guardian of minors to text or email dental appointment reminders to the patients, or send dental x-rays and/or dental photographs to other dental professionals such as specialists or laboratory technicians via a non-encrypted web source. There are risks involved with this, which includes that the message could be read by a third party. The signature below therefore gives the doctor and/or the qualified team of *Lake District Family Dentistry* permission to text/ email myself reminders or other dental professionals my dental x-rays/ pictures as needed for my individual treatment needs.

HIPPA Policy: As health care providers, we are legally required to protect the privacy of your health information and to provide you with this notice about our legal duties and privacy practices. Please read the HIPPA Policy Form before signing below.

I have read the HIPPA Policies and understand all information provided and the above information.

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age) **Date**