

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)			Emergency Contact & Number	
Email Text Phone				
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 regarding your financial obligations?	Email, Text or Voicemail 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**

Consent for Use of Written Testimonial, Audio, Video and Images

I hereby consent to the use of my written testimonials, pictures, voice and/or video recordings for use in any advertising, marketing, publicity, networking or public relations for Lake District Family Dentistry. I further understand that no royalty, fee or other compensation of any character shall become payable to me by Lake District Family Dentistry. I understand that my consent to use words, picture, video and/or voice recordings is voluntary and my refusal to grant consent will have no effect on any benefits or treatment to which I may be entitled. I further understand that I may at any time exercise the right to cease being filmed, photographed or recorded and may, in writing, rescind my consent for previous materials to be used in future advertising contracts.

Please Check One: My full name may be used to identify my testimonials, pictures, voice & video.

- Only use my first name to identify my testimonials, pictures, voice & video. Do not use my name to
- identify my testimonials, pictures, voice & video.

Signature: _____ Date: _____

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