LAKE DISTRICT FAMILY DENTISTRY

CARLTON, RICHTER & MANGUM

Fax: 318-473-8289
Email: frontdesk@lakes-dental.com

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**

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)

LAKE DISTRICT
FAMILY DENTISTRY
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Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception- dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Sincerely,

The Team of Lake District Family Dentistry

_____ _____

Patient Name (Print) Date

_____

Patient Name (Signature)