Lakeside Dental, PA

Family & Cosmetic Dentistry

Medical History Form

Patient Information

Patient's Name: _____
Last First Middle Initial

Social Security _____ **Sex: M F Date of Birth** _____ **Age** _____

If the Patient is a Minor, give Parent's or Guardian's Name _____

Responsible Party Information

Last Name _____ First _____ Middle _____ Marital Status _____
Address _____ City _____ State _____ Zip _____
Driver's License No. _____ Home Phone _____ Work Phone _____
Date of Birth _____ Relationship to Patient _____
Employer _____ Occupation _____ No. of Years Employed _____
Name/Address/Phone No. of nearest relative not living with you _____

How did you hear about us? Please check below:

☐ Yellow Pages ☐ Friend/Relative ☐ Radio Ad. – Which Station? _____ ☐ Bill Board
☐ Sign ☐ Mail Coupon ☐ News Paper – Which one? _____ ☐ Employer
☐ Employee ☐ Health Fairs/Screenings ☐ Other (Specify) _____
Reason for today's dental visit _____
Date of last dental visit _____ Reason _____
Have you ever had an experience in a dental office, that you would like to tell us about? Yes No If Yes, please explain _____
_____

Are you apprehensive about dental treatment?	Yes	No	Are your teeth sensitive to hot, cold, sweets, pressure?	Yes	No
Do your gums bleed, feel tendor or irritated?	Yes	No	Do you have discolored teeth that bother you?	Yes	No
Are you now seeing a physician?	Yes	No	Are you unhappy with the appearance of your teeth?	Yes	No

If so, what is the condition being treated? _____
The Name & Address of my Physician (s) is _____
What medications are you taking now? _____
If female, are you pregnant? Yes No If Yes, how long? _____

Mark any of the following which you have had or have at present:

☐ Heart Disease	☐ Heart Pacemaker	☐ Ulcers	☐ Thyroid Disease	☐ Glaucoma
☐ High Blood Pressure	☐ Diabetes	☐ Emphysema	☐ Chemo. (Cancer, Leukemia)	☐ Pain in Jaw Joints
☐ Blood Disease	☐ Scarlet Fever	☐ Tuberculosis	☐ Arthritis	☐ HIV +
☐ Rheumatic Fever	☐ Anemia	☐ Asthma	☐ Rheumatism	☐ Hepatitis
☐ Heart Murmur	☐ Kidney Trouble	☐ Hay Fever	☐ Cortisone Medicine	☐ Hemophilia
☐ Venereal Disease	☐ Epilepsy or Seizures	☐ Nervousness	☐ Sickle Cell Disease	☐ Bruise Easily

Mark any of the following medications you are allergic to:

☐ Local Anesthetics ☐ Penicillin or other antibiotic ☐ Sulfa Drugs
☐ Aspirin ☐ Codeine or other narcotics ☐ Barbiturates, sedatives, or sleeping pills
☐ Lodine ☐ Other _____

Medical History Updated:

_____ _____ _____
Dr. Date Dr. Date Dr. Date

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change I will inform my dentist at the next appointment.

_____
Signature of Patient / Parent / Guardian

Lakeside Dental, PA

FINANCIAL POLICY

PATIENT NAME: _____

Dear Patient:

Thank you for choosing Lakeside Dental as your dental care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to maintain your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our Office Manager.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the dentist.

Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards. We will be happy to process your insurance claim for you as long as you provide us with adequate information. However, you must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

2. All charges are your responsibility, regardless of whether your insurance company pays. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover.

3. Fees for the services, along with unpaid deductibles and co-payments are due at the time of treatment. We accept cash, checks, or credit cards.

4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite the processing of your claim.

5. If the insurance company does not pay in full within 45 days, we require you to pay the balance due with cash, check, or credit card.

6. You will be responsible for notifying us of any changes in address, job status, insurance status, and availability of benefits immediately. A failure to do so may result in a different balance for which you will be responsible.

7. A 5% courtesy on statements of $500 or more that are paid in full by cash or check prior to or at the time of the first treatment appointment.

8. For patients who wish to pay for treatment over an extended period of time, we offer a payment plan that is administered by an independent company. The Treatment Coordinator will provide you with all the details.

Please do note that unless canceled at least 24 hours in advance, you may be charged for missed appointments at the rate of $25.00. Please call if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your dental provider. We appreciate your trust in us and the opportunity to serve you.

Signature of Patient/Parent/Guardian (if patient is under 18, parent or guardian must sign) Date

Lakeside Dental, PA

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowlegement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Lakeside Dental, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT --- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contracting:

Contact Person: Melissa Sigman

Telephone: 972-292-3092 Fax: 972-292-3093

E-mail: lakeside_dental@hotmail.com

Address: 407 West Eldorado Parkway, Suite 140 Little Elm, TX 75068

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.