904-293-2520
LakewoodDentistryJax.com

Patient Information
Today's Date: _____

Patient Name: _____ **Preferred Name:** _____
Last First MI

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other_____
Responsible Party for child: _____

May we contact you in regards to your account activity using the personal information below? ☐Yes ☐No

SS # Patient: _____**SS # Responsible Party:** _____

Phone (CELL): _____ **(Work)**:_____**(Home):**_____ **Emergency Contact**: _____

Birth Date: _____**E-Mail Address**:_____

Home Address:_____
Street City/State Zip Code

Employer Name: _____ **Position:** _____**How long there?**: _____

Please list other members of your immediate family who are patients in our office that you would like to have linked with your account _____

Referral Information

Can we thank someone for referring you?

Family Member _____
Coworker _____
Friend _____
Doctor _____

Or did you find us on your own?

- ☐ Our Website
- ☐ Yellow Pages
- ☐ Lumineer or 6 Month Braces Referral
- ☐ Insurance Company
- ☐ Location
- ☐ Mail
- ☐ Other _____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit: _____

Do you prefer Nitrous Oxide (laughing gas) during dental procedures? ☐Yes ☐No

Are you interested in sedation dentistry? ☐Yes ☐No

Why did you leave your previous dentist? _____

If you could change your smile and/or oral health, what would you do? *Check all that apply*.

- ☐ Straighter teeth
- ☐ Whiter Teeth
- ☐ Eat and Chew Better
- ☐ Stop snoring
- ☐ Grinding/Clenching/Clicking
- ☐ Close spaces between teeth
- ☐ Lower cavity risk
- ☐ Get rid of ugly dark fillings
- ☐ Better fitting denture
- ☐ Fresher Breath
- ☐ Less Pain in Jaw
- ☐ Taste food better
- ☐ Other_____

Do you prefer to see a particular doctor in our practice? _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

HEALTH QUESTIONNAIRE

Today's Date: ____ /____ /____ Patient Name: _____ DOB: ____ /____ /____

Name of person completing form (if different from patient) and relation to patient: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. All information you provide will be kept confidential.

		If yes, please explain…
Are you under a physician's care now?	☐Y ☐N	
Have you ever been hospitalized or had a major operation?	☐Y ☐N	
Have you ever had a serious head or neck injury?	☐Y ☐N	
Are you taking any medications, pills, or drugs?	☐Y ☐N	**Please list medications currently prescribed:**
Do you take, or have you taken Phen-Fen or Redux?	☐Y ☐N	
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing Bisphosphonates?	☐Y ☐N	
Are you on a special diet?	☐Y ☐N	
Do you currently use tobacco?	☐Y ☐N	**Women: Are you**
Have you ever used tobacco?	☐Y ☐N	☐Pregnant/Trying to get pregnant? ☐Nursing?
Do you use controlled substances?	☐Y ☐N	☐Taking Oral Contraceptives?
Have you ever used controlled substances?	☐Y ☐N	

Are you allergic to any of the following? *Check all that apply*.

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs

☐Other: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐Yes ☐No	Cortisone Medicine ☐Yes ☐No	Hemophilia ☐Yes ☐No	Radiation Therapy ☐Yes ☐No
Acid Reflux ☐Yes ☐No	Daytime Sleepiness ☐Yes ☐No		
Alzheimer's Disease ☐Yes ☐No	Diabetes ☐Yes ☐No	Hepatitis A ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No
Anaphylaxis ☐Yes ☐No	Drug Addiction ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Renal Dialysis ☐Yes ☐No
Anemia ☐Yes ☐No	Easily Winded ☐Yes ☐No	Herpes ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Angina ☐Yes ☐No	Emphysema ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Rheumatism ☐Yes ☐No
Arthritis/Gout ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Excessive Bleeding ☐Yes ☐No	Hive or Rash ☐Yes ☐No	Shingles ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Excessive Thirst ☐Yes ☐No	Hypoglycemia ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Asthma ☐Yes ☐No	Fainting Spells/Dizziness ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	Sinus Trouble ☐Yes ☐No
Blood Disease ☐Yes ☐No	Frequent Cough ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Spina Bifida ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Frequent Diarrhea ☐Yes ☐No	Leukemia ☐Yes ☐No	Gastric/Intest. Disease ☐Yes ☐No
Breathing Problems ☐Yes ☐No	Frequent Headaches ☐Yes ☐No	Liver Disease ☐Yes ☐No	Stroke ☐Yes ☐No
Bruise Easily ☐Yes ☐No	Genital Herpes ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Swelling of Limbs ☐Yes ☐No
Cancer ☐Yes ☐No	Glaucoma ☐Yes ☐No	Lung Disease ☐Yes ☐No	Thyroid Disease ☐Yes ☐No
Chemotherapy ☐Yes ☐No	Hay Fever ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Chest Pains ☐Yes ☐No	Heart Attack/Failure ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Cord Sores/Fever Blisters ☐Yes ☐No	Heart Murmur ☐Yes ☐No	Pain in Jaw Joints ☐Yes ☐No	Ulcers ☐Yes ☐No
Congenital Heart Disorder ☐Yes ☐No	Heart Pacemaker ☐Yes ☐No	Parathyroid Disease ☐Yes ☐No	Venereal Disease ☐Yes ☐No
Convulsions ☐Yes ☐No	Heart Trouble/Disease ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	Yellow Jaundice ☐Yes ☐No

Have you ever had any serious illness not listed above? ☐Yes ☐No If Yes, please explain _____

_____

I also understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

____ /____ / ____ _____ _____

Date **Print Name of person completing forms** **Signature of person completing forms**

INSURANCE INFORMATION

Primary Dental Insurance *if available*

Dental Insurance Company: _____ Policy Holder's Employer:_____

Policy Holder's Name: _____ Policy Holder's SS#: _____
Last First MI

Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

Secondary Dental Insurance *if available*

Dental Insurance Company: _____ Policy Holder's Employer:_____

Policy Holder's Name: _____ Policy Holder's SS#: _____
Last First MI

Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

Medical Insurance

Medical Insurance Company: _____ Policy Holder's Employer:_____

Policy Holder's Name: _____ Member ID#: _____
Last First MI

Policy Holder's Date of Birth: _____ Insurance Co. Phone #: _____

OPTION TO AUTHORIZE RELEASE OF INFORMATION TO FAMILY MEMBERS

Today's Date: ____ /____ /____ Patient Name:_____ DOB: ____ /____ /____

Many of our patients allow family members such as their spouse, parents, or others to call and request dental or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to the family members listed below.

I authorize Lakewood Dentistry to release my dental and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Please list all authorized person(s) who will bring your child/children to their dental appointment. We require a six month medical update to be completed at your child's appointment, thus making the person bringing your child to the appointment responsible for any medical changes, current medications and dental concerns.

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by the federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing

____ /____ / ____ _____ _____
Date **Print Name of person completing forms** **Signature of person completing forms**

CONSENT FOR SERVICES AND FINANCIAL POLICY

Thank you for choosing Lakewood Dentistry as your premier Dental Care Provider. We are fully committed to making your experience and dental care here as comfortable and extraordinary as possible. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. As a condition of your treatment by this office, financial arrangements must be made in advance. Please understand that payment of your bill is considered a part of your treatment. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CARE CREDIT

DENTAL INSURANCE:
Your coverage depends solely on what your employer purchases. Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ***ESTIMATED*** co-payment by the day services are rendered. We will gladly file your insurance claim. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. If a balance is left on the account after 60 days, a statement of accounts will be sent and payment for any balance over 60 days will be due and payable by you and summed with interest charges. Any accounts with a remaining balance over 90 days old may be turned over to an attorney or collections agency.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will require a signed consent form and payment at time of scheduling.

MISSED APPOINTMENTS
We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION & RELEASE
I authorize this office to perform diagnostic procedures (exams, x-rays, study models, and photographs) appropriate to make thorough diagnosis of the patient's dental needs. I also authorize this office to perform any and all treatment that may be indicated. I authorize the practice to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to Lakewood Dentistry (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due. In the event it should become necessary to place this account in the hands of an attorney or collection agency, you will be responsible to pay all collection fees (up to 50% of my account balance), plus attorney fees. I understand there is a $30 fee for each returned check. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand Lakewood Dentistry may need to verify my information and/or evaluate my credit history for purposes of setting up financing or insurance benefits for myself or my dependents. For quality assurance, I agree to have any photos, and/or video/audio recordings taken of me to be used for educational and training purposes.
Privacy: I have been informed of, and given the right to review and secure a copy of this office's *Notice of Privacy Practices*, which contains a complete description of the uses and disclosures of my protected health information, and my rights under HIPPA (the Health Insurance Portability and Accountability Act of 1996).

By signing below, I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian