



**904-293-2520**  
LakewoodDentistryJax.com

**Patient Information**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

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? \_\_\_\_\_



## 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