LIFETIME DENTAL
Keeping everyone Smiling!

PERSONAL INFORMATION DATE _____

NAME _____ DATE OF BIRTH _____ SSN _____ - _____ - _____

HOME ADDRESS _____CITY/STATE/ZIP _____

HM PHONE _____ CELL _____ WORK _____

PLEASE CHECK: _____ MALE _____ FEMALE _____ MINOR _____ SINGLE _____ MARRIED

EMAIL _____ EMPLOYER _____

Whom may we thank for referring you? _____

SPOUSE INFORMATION

SPOUSE NAME _____ DATE OF BIRTH _____ SSN _____ - _____ - _____

CELL _____ WORK _____ EMPLOYER _____

RESPONSIBLE PARTY for dependents – Who is responsible for paying the account if patient is a minor?

NAME _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ SSN _____ - _____ - _____ DL# _____ STATE _____

PRIMARY DENTAL INSURANCE

NAME OF INSURED _____ DATE of BIRTH _____ SSN _____ - _____ - _____

EMPLOYER _____ EMPLOYER'S PHONE NUMBER _____

NAME of INSURANCE CO._____ GROUP# _____ POLICY# _____

SUBSCRIBER ID# _____ INSURANCE PHONE NUMBER _____

INSURANCE MAILING ADDRESS _____ CITY _____ STATE _____ ZIP_____

AUTHORIZATION AND RELEASE (PLEASE INITIAL)

_____I authorize the dentist to release any information including the diagnosis and the records for any treatment rendered during the period of such Dental care to third party payers and/or other health care practitioners as required.

_____I authorize and request my insurance company to pay directly to the dentist benefits payable to me.

_____I understand that my dental 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 and/or of my dependents within 45 days of service.

Regarding Dental Insurance: Patients who have dental insurance understand that the professional services are rendered and charged to the patients. Claims will be filed to your insurance carrier on your behalf, but the patient/responsible party is ultimately responsible for all charges not paid for by your insurance. Patient portion estimates are only estimates and not a guarantee of payment. Payment is due in full within 45 days of date of service.

FINANCIAL ARRANGEMENT POLICIES

Payment is due in full when services are rendered. If your insurance has been verified prior to your appointment, your estimated portion is due at the time of service. Our office accepts: CASH, CHECKS, VISA, MASTERCARD, DISCOVER, LENDING CLUB and CARE CREDIT. Checks with insufficient funds will incur a $25 NSF fee. Accounts over 90 days past due with no payment activity may be turned over to a collection agency, and you will be responsible for all fees associated with the bad debt process. At least a 24-business hours notice is required for all appointment changes or missed appointments. Fees may be applied to my account for No-Shows or short cancellations. A 1.5% monthly interest will be charged to my account for all balances due over 60 days.

I have read, understand and agree to the above information and Lifetime Dental policies.

Signature of Responsible Party _____ **Date** _____

You may be reminded of your appointments by TEXT, EMAIL, and/or a PHONE-CALL.

Please let us know if you would like to OPT OUT of any of our communication preferences.

CANCELLATION and NO-SHOW POLICY

We understand that situations arise in which you must cancel and reschedule your appointment. We kindly request that if you must cancel or reschedule an appointment, you please provide our office with at least a 24-business hours notice. This courtesy will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

We reserve the right to charge patients a fee and/or terminate our relationship with a patient who fails to keep their appointments without notifying our office in advance. Patients who No-Show three consecutive times may be dismissed from the practice and thus, be denied any future appointments.

Our practice believes that a good dentist/patient relationship is based upon understanding and communication. Questions about cancellation and no show fees should be directed to the front office.

I have read, understand, and agree to this Cancellation/No-Show Policy.

Signature of Responsible Party _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received or been offered a copy of Lifetime Dental's Privacy Policy, which describes how we may use and disclose your protected health information to carry out treatment, obtain insurance payment or share healthcare information, or for other purposes that are permitted or required by law (HIPPA). Our office will gladly provide you a copy for your records.

Signature of Responsible Party _____ **Date** _____

I authorize the following individual(s) to discuss my treatment, insurance and payment information with Lifetime Dental:

Name _____ Relationship _____

Name _____ Relationship _____

DENTAL HEALTH

When was your last dental visit? _____ How often do you see your dentist? _____

Are you having any problems that require immediate attention? _____

What is your chief dental concern? _____

Do any of the following cause tooth discomfort? _____HOT _____ COLD _____ SWEETS _____ CHEWING

Do you floss? How often? _____ Do you use a water pick or electric toothbrush? _____

Have you ever been told you have/had gum disease? ____ Yes ____ No Do your gums bleed? ____ Yes ____No

Do you clench or grind your teeth? ____ Yes ____ No Do your jaw joints: ____POP ____ CLICK ____ ACHE

Have you ever had orthodontic treatment? ____Yes ____ No If so, when? _____

Do you have frequent headaches? ____ Yes ____ No

Are you pleased with the appearance of your smile? _____

Are you interested in teeth whitening or veneers? _____

Have you ever had an unpleasant dental experience? _____

MEDICAL HEALTH

Primary Physician's Name _____ Phone _____

Have you been under the care of a physician during the past 2 years? ____ Yes ____ No

If yes, for what reason? _____

Have you had or do you now have:

	YES	NO		YES	NO
Abnormal Blood Pressure…….	____	____	Fainting……..	____	____
AIDS/HIV…….....	____	____	Heart Disease……...	____	____
Alcohol Dependency…….	____	____	Heart Murmur……...	____	____
Allergies……..	____	____	Hepatitis…….....	____	____
Alzheimer's……...	____	____	Organ Transplant…….	____	____
Anemia……..….	____	____	Pacemaker.....……..	____	____
Angina…….....	____	____	Prolonged Bleeding….	____	____
Arthritis……..…	____	____	Psychiatric Treatment..	____	____
Artificial Heart Valves……...	____	____	Radiation Treatment….	____	____
Artificial Joints……..	____	____	Rheumatic Fever…..…	____	____
Asthma……...	____	____	Sickle Cell Anemia..…	____	____
Cancer……..	____	____	Sinus Problems.....….	____	____
Canker/Cold Sores……	____	____	Snoring/Sleep Apnea...	____	____
Chemotherapy……...	____	____	Stroke……	____	____
Diabetes.....….....	____	____	Thyroid Disease……	____	____
Drug Dependency. ……	____	____	Tuberculosis…….	____	____
Epilepsy/Seizures……..……	____	____			
Do you use Tobacco Products?	____	____	If yes, what type?_____		

Do you have any other medical conditions or serious illnesses that are not listed above?_____

_____

_____

Please list any medications you currently take and its purpose:

NAME OF DRUG/DOSAGE PURPOSE DATE

_____

_____

_____

_____

_____

Do you take any blood thinners? ___ Yes ___ No If yes, what? _____

ALLERGIES

Penicillin ___Yes ___ No **Codeine** ___ Yes ___ No **Latex** ___Yes ___ No **Sulfa** ___ Yes ___ No

Local Anesthetic ___Yes ___ No **Non-Gold Jewelry** ___ Yes ___ No **Other** _____

WOMEN ONLY: Are you pregnant or nursing? _____ Are you taking hormones or birth control pills? _____
ALERT: Antibiotics can neutralize the effect of birth control pills up to six weeks.

HAVE YOU EVER BEEN TOLD THAT YOU NEEDED TO PRE-MEDICATE WITH AN ANTIBIOTIC PRIOR TO DENTAL PROCEDURES? ____ Yes ____ No
The American Heart Association recommends prophylactic antibiotic coverage prior to dental appointments for the following conditions: Artificial Cardiac Valves; Previous Infective Endocarditis; Congenital Heart Disease; Cardiac Transplantation; Prosthetic Joints.

May we use photos of your teeth/smile for training or advertising purposes? ____ Yes ____ No

Signature of Responsible Party _____ **Date** _____