LM Family Dentistry

Patient Information **PLEASE PRINT**

Patient Name_____Date of Birth_____

Hm Phone_____Cell Phone & Carrier_____Wk Phone_____
_____

Home Address_____

City_____State_____Zip_____SS#_____

Email Address_____

Marital Status_____ Sex: M_____F_____

Spouse's Name_____Phone_____

Nearest relative not living with you_____Phone_____

Nearest friend not living with you_____Phone_____

Whom may we contact in case of an emergency?
_____Phone_____

Whom may we thank for referring you to us?
_____Phone_____

Who is responsible for this bill?_____

I will be paying today by Cash_____Check_____Credit_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature_____Date_____
(If under 18, Parent of Guardian Signature Required)

INSURANCE INFORMATION

Name of Insurance Carrier_____

Address where claim is to be mailed_____

Insurance phone number_____Group number _____

Name of Employer_____

Employer
Address_____.

City _____State _____Zip _____Phone #_____
.

Name of Employee_____SS#_____D.O.B
.
(Primary Card Holder)

Please complete this section if you have a secondary Insurance

Name of Insurance Carrier_____

Address where claim is to be mailed_____

Insurance phone number_____Group number _____

Name of Employer_____

Employer
Address_____.

City _____State _____Zip _____Phone #_____

.

Name of Employee_____SS#_____D.O.B

(Primary Card Holder)

Patient Medical History

Patient's Name_____Date of Birth_____Sex_____

Pharmacy_____Pharmacy Phone_____

Primary Physician_____Phone_____

Please answer the following:

Do you smoke or use tobacco?_____

Height_____Weight_____

If female please answer the following:

Are you Pregnant?_____If yes, # of weeks_____

Are you taking Birth Control?_____Are you Nursing?_____

Y	N	Conditions
___	___	Abnormal bleeding
___	___	Alcohol Abuse
___	___	Allergies
___	___	Anemia
___	___	Angina Pectoris
___	___	Arthritis
___	___	Artificial Bones
___	___	Artificial Heart Valve
___	___	Asthma
___	___	Blood Transfusion
___	___	Cancer-Chemotherapy
___	___	Colitis
___	___	Congenital Heart Defect
___	___	Cosmetic Surgery
___	___	Diabetes
___	___	Difficulty Breathing
___	___	Drug Abuse
___	___	Emphysema
___	___	Epilepsy
___	___	Fainting Spells
___	___	Fever Blisters
___	___	Frequent Headaches

Y	N	Conditions
___	___	Glaucoma
___	___	Hay Fever
___	___	Heart Attack
___	___	Heart Surgery
___	___	Hemophilia
___	___	Hepatitis A
___	___	Hepatitis B
___	___	High Blood Pressure
___	___	HIV + AIDS
___	___	Kidney Problems
___	___	Liver Disease
___	___	Low Blood Pressure
___	___	Mitral Valve Prolapse
___	___	Pace Maker
___	___	Pneumocystitis
___	___	Psychiatric Problems
___	___	Radiation Therapy
___	___	Rheumatic Fever
___	___	Seizures
___	___	Shingles
___	___	Sickle Cell Disease
___	___	Sinus Problems

Y	N	Conditions
___	___	Stroke
___	___	Thyroid Problems
___	___	Tuberculosis
___	___	Ulcers
___	___	Venereal Disease
___	___	Yellow Jaundice

Y	N	Allergies
___	___	Aspirin
___	___	Codeine
___	___	Dental Anesthetics
___	___	Erythromycin
___	___	Jewelry
___	___	Latex
___	___	Metals
___	___	Penicillin
___	___	Tetracycline

Other: _____.

List any Medications currently taking:

Is there any disease, condition, or problem that you think the office should know about that is not covered above? If yes, please describe below:

Any additional Notes:

Signature_____Date_____
(If under 18, Parent or Guardian Signature Required)

Financial Policy

About Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of you payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, American Express, Discover or Visa. **Insurance deductibles and coinsurances are due at the time services are rendered.**

Returned checks and balances older than **30** days may be subject to additional collection fees and interest charges of **1.5%** per month. A charge of **$50** will be made for broken appointments and appointments cancelled without **24 hours** advanced notice. Failure to contact our office in advance prohibits our providers from treating other patients who are in need of care and creates a hardship on the practice.

You are expected to notify our office if your insurance coverage changes. Our office will periodically ask you to update your records. You will be expected to provide full and complete information to our office in order to correctly bill your insurance company. For serviced rendered to minor patients, we will look to the parents or guardian with custody for payment. A minor consent form will be required before we can treat a child in the absence of the parent or guardian.

We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however, that:

1. *Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.*
2. *Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R." is defined as usual, customary, and reasonable.*

This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that, as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realized that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by practice.

Signature_____Date_____

Print Name of Patient or Minor_____Date_____

INFORMED CONSENT

CONFIDENTIALITY STATEMENT:

All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to confer with another healthcare professional, you will need to sign a "Release of Information" form. This permission can be revoked by you at any time.

FINANCIAL AGGREEMENT:

Your fee per visit is payable at the time of your treatment. We accept cash, personal check, cashiers check, money order, Visa, MasterCard, American Express and Discover.

NO-SHOW AND CANCELLATION POLICY:

Your visit has been reserved for you. 24 hours notice is required for cancellation or you will be charged a late cancellation fee of $50 dollars.

AUTHORIZATION:

You authorized the staff to perform any necessary services during diagnosis and treatment. You also authorize the provider to release any information required to process insurance claims.

MINORS:

If the patient is a minor, you hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION. FEES ARE SUBJECT TO CHANGE EVERY 12MONTHS.

STATEMENT OF UNDERSTANDING

I certify that all answers to the health questions are correct. I understand the importance of and agree to notify the doctor of any changes at any subsequent appointment, I give my consent for the dental treatment that the dentist indicates necessary. I also agree to the use of local anesthetics, as needed.

I have read and understand this information sheet and informed consent.

Signature_____Date_____

Print Name of Patient or Minor_____Date_____

Our Promise!

Dear Patients:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking to new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentially of your health information seriously. We do not ever want to delay treatment because you are afraid your personal health history might be unnecessarily made available to other outside of our office.

How Your Health Information May Be Used

To Provide Treatment:

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant and business office staff. In addition we may share your health information with physicians, referring dentist, clinical and dental laboratories, pharmacies or other health care personal providing your treatment.

To Obtain Payment:

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail. We will be sure to only work with companies with similar commitment to the security of your health information.

To Conduct Health Care Operations:

Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situation experienced by patients receiving care at our office. As a result, insurance companies or government appointed agencies as part of their quality assurance and compliance reviews will disclose health information during audits. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

Abuse or Neglect:

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

For Law Enforcement:

As permitted or required by State or Federal Law, we may disclose you health information to law enforcement official for certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers:

We may share your information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask for permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your information only when it will be important to those providing your care.

I have read and agree to the above policies. I have been given the opportunity to ask questions on the above policies.

Signature_____Date_____

(If under 18, Parent of Guardian Signature Required)