Lakeshore

Dental

First Name: ____________________ **Last Name**: ____________________ **MI**: ___ **Preferred Name**: _________

Address: ____________________________ **City**: _______________ **State**: _______ **Zip Code**: ___________

Date of Birth: _____/_____/_________ **Gender**: M or F **Family Status**: Married Single Divorced Widowed

Driver's License: ______________________________ **SSN**: ________-______-___________

Home Phone: (_____) _____-__________ **Work Phone**: (_____) _____-__________

Cell Phone: (_____) _____-__________ **e-mail address**: ____

<u>Emergency Contact</u>

Name: __________________________________ **Relationship**: ______________________________________

Cell Phone: (_____) _____-__________ **Phone**: (_____) _____-__________

Medical History

- ❑ *PREMED
- ❑ AIDS
- ❑ Allergy - Allergies
- ❑ Allergy - Aspirin
- ❑ Allergy - Codeine
- ❑ Allergy - Darvocet
- ❑ Allergy - Demerol
- ❑ Allergy - Erythromycin
- ❑ Allergy - Keflex
- ❑ Allergy - Penicillin
- ❑ Allergy - Sulfa
- ❑ Allergy - Tetanus
- ❑ Allergy - Tetracycline
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Epinephrine Sens.
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Hearing Problems
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Hypoglycemia
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Latex
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lupus
- ❑ Mental Disorders
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ MVP

- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Pregnancy
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Seizures
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Taking Coumadin
- ❑ Taking Ritalin
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease

Do you have any other health problems? No Yes

If Yes please explain, ____

____

Are you taking any medications at this time? No Yes

If Yes please explain, ____

____

Have you been admitted to a hospital in the last 2 years? No Yes

If Yes please explain, ____

____

Physician's name and phone number: ______________________________

Do you use tobacco? No Yes **Do you use alcoholic beverages?** No Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? No Yes

Have you ever taken diet drug such Fen-Phen? No Yes

Women: Are you pregnant? No Yes If Yes, how many weeks? __________ Due Date: ____________

Women: Do you take birth control medications? No Yes

Women: Are you nursing? No Yes

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

X______________________________

signature

Dental History

Why are you changing dentists?

- ❑ Change of residence
- ❑ Change of dental plan
- ❑ Your office is closer
- ❑ My dentist retired/closed
- ❑ Unhappy
- ❑ Too expensive
- ❑ You were recommended
- ❑ Other

How long since the last visit to the dentist?

- ❑ 1 month
- ❑ 3 months
- ❑ 6 months
- ❑ 1 year
- ❑ 2 years
- ❑ 3 or more years
- ❑ I've never seen a dentist

How did you find us?

- ❑ Other Patient
- ❑ Dental Office
- ❑ Yelp Google
- ❑ Internet
- ❑ Yellow Pages
- ❑ Mailer
- ❑ Work
- ❑ School
- ❑ Insurance Company
- ❑ Other

Reason for the visit

- ❑ Check-up
- ❑ Cleaning
- ❑ Pain
- ❑ Other

Have you ever had a bad experience at the dentist? No Yes

If Yes please explain, ____

____

Have you had any complications following dental treatment? No Yes

If Yes please explain, ____

____

Have you had an unfavorable reaction to dental anesthetic? No Yes

If Yes please explain, ____

____

Does dental treatment make you nervous?

- ❑ No
- ❑ Yes, Slightly
- ❑ Yes, Moderately
- ❑ Yes, Extremely

Are your teeth sensitive to cold, hot? No Yes **Do you grind your teeth?** No Yes

Do your gums bleed when you brush or floss? No Yes **Are you aware of sores or irritated areas in the mouth?** No Yes

Have you ever been treated for Periodontal Disease? No Yes

How often do you brush?

- ☐ Once a day
- ☐ Twice a day
- ☐ Three times a day
- ☐ Every time I eat

How often do you floss?

- ☐ Never
- ☐ Occasionally
- ☐ Once a day
- ☐ Twice a day
- ☐ Three times a day
- ☐ Every time I eat

Do you like your smile? No Yes

If you could change your smile, what would you like to change?

- ☐ The color of my teeth
- ☐ Close spaces or restore worn and broken teeth
- ☐ The shape of my teeth
- ☐ The position or alignment of my teeth
- ☐ Other
- ☐ If Other please specify

____

____

I am interested in:

- ☐ Teeth whitening
- ☐ Cosmetic evaluation
- ☐ Replacement of missing teeth
- ☐ Straight teeth
- ☐ Sedation
- ☐ White fillings
- ☐ Home care
- ☐ Breath control
- ☐ Other
- ☐ If Other please specify

____

____

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.

____

____

Primary Dental Insurance Information

Subscriber's First Name: ____________________ **Subscriber's Last Name:** ____________________

Date of Birth: _____/_____/__________ **Gender: M or F** **SSN**: ________-______-____________

Home Phone: (_____) _______-____________ **Cell Phone**: (_____) _______-____________

Relationship to patient: Spouse Parent Other: ____________________________

Employer Name: ____________________________________ **Occupation:** ______________________________

Employer Address: __________________________________ **City**: ______________________ **State**: _______

Zip Code: ____________ **Work Phone**: (_____) _____-__________

Insurance Company Name: ____________________________________ **Phone:** (_____) _____-__________

Address: ____________________________ **City**: _______________ **State:** _______ **Zip Code:** ____________

ID Number: ______________________________ **Group Number:** _______________________________

Secondary Dental Insurance Information

Subscriber's First Name: ____________________ **Subscriber's Last Name:** ____________________

Date of Birth: _____/_____/__________ **Gender: M or F** **SSN**: ________-______-____________

Home Phone: (_____) _______-____________ **Cell Phone**: (_____) _______-____________

Relationship to patient: Spouse Parent Other: ____________________________

Employer Name: ____________________________________ **Occupation:** ______________________________

Employer Address: __________________________________ **City**: ______________________ **State**: _______

Zip Code: ____________ **Work Phone**: (_____) _____-__________

Insurance Company Name: ____________________________________ **Phone:** (_____) _____-__________

Address: ____________________________ **City**: _______________ **State:** _______ **Zip Code:** ____________

ID Number: ______________________________ **Group Number:** _______________________________

Truth In Lending

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time of services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can be extended for a period of six months from the date of consultation. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a waiver of any further term or condition and further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

I acknowledge that I have read the above conditions of treatment and payment and agree to their content.

__________________________________ Date: ______________________

(signature)

____

(printed name)

Hipaa

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly -Obtain payment from designated third-party payers.

-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link {https://yapi.me/shared/hipaa2013.pdf} or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Lakeshore Family Dental Care has the right to change its Notice of Privacy Practices from time to time and that I may contact Lakeshore Family Dental Care at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Lakeshore Family Dental Care restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Lakeshore Family Dental Care is not required to agree to my requested restrictions, but if Lakeshore Family Dental Care does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Lakeshore Family Dental Care has taken action relying on this consent.

Please list any other parties who can have access to patient's health information.

Name: ______________________________

Relationship: ______________________________

Name: ______________________________

Relationship: ______________________________

Name: ______________________________

Relationship: ______________________________

Name: ______________________________

Relationship: ______________________________

504 E. Colby St. | Whitehall, Michigan 49461
Phone: (231) 894-8814 | Fax: (231) 893-6505
LakeshoreFamilyDentalCare504@gmail.com

Records Release Request

Patient name of transfer: ______________________________

Date of Birth: ____________________ Phone number: ____________________

Other family members: ______________________________

I hereby give you permission to release any and all of my dental records to:

____
(New dental office/Dr.'s name)

____
(New dental office address)

____
(New dental office email)

Patient/Guardian Signature: ______________________________ Date: ____________

Lakeshore
Dental

COVID-19 Screening Questions

Do you have a fever or above normal temperature?	Yes	No
Have you experienced shortness of breath or had trouble breathing?	Yes	No
Do you have a dry cough?	Yes	No
Do you have a runny nose?	Yes	No
Have you recently lost or had a reduction in your sense of smell?	Yes	No
Do you have a sore throat?	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	Yes	No
Have you tested positive for COVID-19?	Yes	No
Have you been tested for COVID-19 and are awaiting results?	Yes	No
Have you traveled outside the US in the past 14 days?	Yes	No

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided are true and accurate.

______________________________ ____________________

signature date

Lakeshore
FAMILY Dental CARE

CANCELLATION POLICY

I understand that by scheduling an appointment I am reserving time especially for me with Dr. Bown, Dr. Brunworth, and the clinical team. LAKESHORE FAMILY DENTAL CARE will make every effort to ensure that your time at our office is both pleasant and productive. We take pride in the fact that our appointments are efficient and you are not subject to lengthy waits in our reception area.

In the event that you are not able to make a scheduled appointment **please be courteous and provide our office with at least 24 hours notice.** This allows us to offer that appointment time to another patient.

If you fail to let us know that you will not be able to attend your scheduled appointment--or need to reschedule--with less than 24 hours notice it will be considered a *"failed"* or *no-show* appointment. **We do not like to charge patients for missed appointments, however we do reserve the right to charge a fee ranging from $25-$100 depending on the length of time that was reserved for your appointment or the frequency in which insufficient notice has been provided.**

Late Arrival: Patients arriving more than 15 minutes late for their appointment will need to be rescheduled. This policy is necessary for us to be certain that we stay on time, and to ensure we don't penalize our patients arriving on time for their appointments by forcing them to wait.

Thank you for your cooperation! Please sign on the New Patient Registration Form to acknowledge this policy.