Welcome to Lakeshore FAMILY Dental CARE

Last Name: _____ Legal First Name: _____ M.I. ___ Preferred Name: _____
Home Address: _____ City: _____ State: _____ Zip_____
Home Phone: (___) _____ Work Phone: (___) _____ Ext: ____ Cell Phone: (___) _____
E-Mail Address_____ Drivers License #: _____
DOB: ___/___/___ Age: ____ SS#:_____ □Male □ Female □ Single □ Married □ Divorced □ Widow
Employer: _____How Long? _____ Occupation: _____
Employer's Address: _____City: _____ State:_____ Zip_____
Spouse's Name: _____ Who referred you to our office? _____
Emergency Contact _____ Relation: _____
Home Phone: (___) _____Work Phone: (___) _____ Ext: ____ Cell Phone: (___) _____

Primary Dental Insurance Coverage

Subscriber Name: _____ DOB: ___/___/___ SS#:_____
ID# _____ Group #: _____ Insured's Employer:_____
Insurance Company Name: _____ Phone: (_____) _____

Secondary Dental Insurance Coverage

Subscriber Name: _____ DOB: ___/___/___ SS#:_____
ID# _____ Group #: _____ Insured's Employer:_____
Insurance Company Name: _____ Phone: (_____) _____

MEDICAL HISTORY

***Do you have a medical condition that requires antibiotic pre-medication before dental treatment? □ Yes □ No**
Please list all medications you are currently taking _____
_____

Do you use tobacco? □ Yes □ No If so, how often? _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

□ AIDS/HIV+
□ Alcohol/Drug Abuse
□ Anemia
□ Arthritis
□ Artificial Bones/Joints
□ Artificial Valves
□ Asthma
□ Back Problems
□ Bleeding Problems
□ Blood Thinners
□ Cancer/Tumors
□ Cosmetic Surgery
□ Diabetes
□ Emphysema
□ Epilepsy/Seizures
□ Fainting
□ Glaucoma
□ Headaches (Severe)
□ Heart Attack
□ Heart Disease
□ Heart Surgery
□ Heart Murmur
□ Hepatitis A, B, or C
□ High Blood Pressure
□ Low Blood Pressure
□ Kidney Problems
□ Liver Problems
□ Mental Disorders
□ Mitral Valve Prolapse
□ Pacemaker
□ Radiation/Chemo
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Thyroid Problems
□ TMJ/TMD
□ Tuberculosis TB
□ Ulcers
□ Venereal Disease

Please list any surgeries or medical conditions you have had:_____
_____

Are you allergic to any of the following? □ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Sulfa
□ Dental anesthetics □ Foods: _____ □ Others: _____
Pharmacy Name & Location _____

For Women: Are you taking Birth Control Pills? o Yes o No How many children have you had? _____
Are you Pregnant? □ Yes □ No If yes how many weeks? _____ Due Date: _____ Are you nursing? □ Yes □ No

Signature _____ Date _____/_____/_____

□ Parent or Guardian □ Spouse

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: _____ Date of Birth: _____

Previous Dental Office: _____

Name(s) of family members to transfer: _____

_____

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: _____

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