Thank you for choosing our office. In order to serve you properly, we will need the following information.

All information will be strictly confidential

First Name: _____ Last Name: _____ MI: ___

Gender: Male Female Status: Single Married Divorced Widowed Separated

Date of Birth: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Other: _____

Email: _____

Emergency Contact: _____

Phone Number: _____ Relationship to patient: _____

PERSON RESPONSIBLE, IF DIFFERENT THAN THE PATIENT

First Name: _____ Last Name: _____ MI: ___

Relationship to patient: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Other: _____

_____

Patient, Parent or Guardian Signature Date

Thank you for choosing our office. In order to serve you properly, we will need the following information.

All information will be strictly confidential

First Name: _____ Last Name: _____ MI: ___

Gender: Male Female Status: Single Married Divorced Widowed Separated

Date of Birth: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Other: _____

Email: _____

Emergency Contact: _____

Phone Number: _____ Relationship to patient: _____

PERSON RESPONSIBLE, IF DIFFERENT THAN THE PATIENT

First Name: _____ Last Name: _____ MI: ___

Relationship to patient: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Other: _____

_____

Patient, Parent or Guardian Signature Date

Have you ever had any of the following health problems, conditions or habits? Please check all that apply:

__ Aids
__ Anemia
__ Arthritis, Rheumatism
__ Artificial Heart Valves
__ Artificial Joints, Pins
__ Asthma
__ Back Problems
__ Bleeding Abnormally
__ Blood Disease
__ Cancer
__ Chemical Dependency
__ Chemotherapy
__ Circulatory Problems
__ Hemophilia
__ Swelling of Feet/Ankles
__ Hernia Repair
__ Diabetes
__ Dizziness
__ Epilepsy
__ Excessive Bleeding
__ Faintaing
__ Glaucoma
__ Growths
__ Hay Fever
__ Headaches
__ Head Injuries
__ Heart Disease
__ Heart Murmur
__ Cortisone Treatment
__ Stomach Problems
__ Hepatitis
__ Jandice
__ Mental Disorders
__ Mitral Valve Prolapsed
__ Nervous Disorders
__ Pacemaker
__ Radiation Treatment
__ Respiratory Problems
__ Rheumatic Fever
__ Rheumatism
__ Scarlet Fever
__ STD
__ Shortness of Breath
__ Skin Rash
__ Cough Persitent
__ Smoking # __ years
__ Substance Abuse
__ Congenital Heart Defect
__ Thyroid Problems
__ Tobacco Habit
__ Tonsillitis
__ Tuberculosis
__ Tumors
__ Ulcers
__ Jaw Pain
__ Liver Disease
__ Kidney Disease
__ High Blood Pressure
__ Cough up Blood
__ Other: _____

Are you allergic to any medication(s)? _____

_____

Have you ever had any of the following dental problems or conditions? Please check all that applu:

__ Bad Breath
__ Bad Taste
__ Bleeding Gums
__ Clicking/Popping of Jaw
__ Food caught between teeth
__ Grinding/Clenching teeth
__ Loose Teeth
__ Broken Fillings
__ Periodontal Treatment
__ Sensitivity to cold
__ Sensitivity to hot
__ Sensitivity when biting
__ Sores in the mouth
__ Prolonged Bleeding
__ Braces

Please answer the following Dental/Medical Questions:

- Have you ever been, or do you need to be pre-medicated for dental work? __ Yes __ No
- How often do you floss? _____
- How often do you brush? _____
- Have you ever worn dentures or partials? __ Yes __ No If so, how old are they? _____
- Have you ever had any complications following dental treatment? __ Yes __ No
  If so, explain? _____
- Are you pregnant? __ Yes __ No Are you nursing? __ Yes __ No
- Are you taking birth control pills? __ Yes __ No
- Are you now under the care of a physician? __ Yes __ No
  If so, explain? _____
  Name of Physician: _____ Phone #: _____
- Do you have health problems that need further clarification? __ Yes __ No
  If so, explain? _____
- Please list all the medications currently being taken and for what medical condition:
  _____

I certify that I have read and understand the information above. All of my questions have been answered with exactitude, to the best of my knowledge. I understand that submitting the wrong information on this questioner can be hazardous to my health.

_____ _____ _____

Name of Patient Signature of Resp. Party Date

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of insured: _____ Relationship to Patient: _____

Insured Birth Date: _____

Insurance Plan Name: _____ Insurance CO Phone #: _____

Claim Address: _____

City, State, Zip: _____

Group #: _____ ID #: _____

SECONDARY INSURANCE

Name of insured: _____ Relationship to Patient: _____

Insured Birth Date: _____

Insurance Plan Name: _____ Insurance CO Phone #: _____

Claim Address: _____

City, State, Zip: _____

Group #: _____ ID #: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Phone #: _____

Address: _____

City, State, Zip: _____

OR

__ I have NO dental coverage

By signing this, I agree that the information provided is valid.

_____ _____

Patient's or Parent's/Guardian's Signature Date

Our goal is to provide dental services to you in the most beneficial manner possible. This requires our mutual understanding. Please read the following information carefully and ask questions about anything you do not understand. We will answer all your questions and concerns.

1. I hereby authorize and direct Dr. _____ assisted by other dentist and/or dental assistants of his choice to perform dental treatment witht hr use of any necessary or advisable radiographys (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by certified paraprofessionals (dental assistants) other than the dentist.
3. I understand that during treatment it may be necessary to change or add procedures because conditions were found while working that were not visible during examination; the most common being root canal therapy following restorative procedures. Any changes made will result in a change of fees originally discussed. I hereby give my permission for Dr. _____ to make any changes and additions as necessary.
4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aids used for accurate diagnosis and treatment plan are the property of the doctor but copies are available upon request.
5. In general terms, the dental procedure(s) can include but are not limited to:
    - Comprehensive oral examination, radiographs, and cleaning of the teeth.
    - Treatment of diseased or injured oral tissues secondary to traumatic injuries, and/or accidents and/or infection.
    - Construction of full or partial plastic, metal and/or porcelain dentures.
    - Use of anesthesia agents and/or antibiotic and analgesics.
6. I understand the doctor is not responsible for previous dental treatment. I understand that in the course of treatment this previous existing dentistry may need adjustments and/or replacements.
7. I realize the guarantees of results or absolute satisfaction are not possible in dental health services.
8. I have answered all the questions about my medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies that might indicate that I should not receive oral medications and/or anti-anxiety agents. I also understand that if I ever have any changes in health status or any changes in medication(s). I will inform the doctor at the next appointment.
9. I authorize Dr. _____ to forward a review of finding and/or any other dental information to the reffering doctor (if such has been the referral source) or any other health care provider for his/her records as well as any third party such as insurance companies that may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its content. All the questions I had have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand this consent shall remain in effect until terminated by me.

_____	_____	_____
Patient Signature	Name of Patient	Date

Patient's Name: _____ Date: _____

Financial Policy

Thank you for choosing Dr. _____. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients, as possible. Please help us in the following ways.

- Always bring your current dental insurance card to the office.
- Please notify us at the time of check-in of any change in insurance, address, phone numbers, etc.
- Please double check with your plans as to the participating status of the office. If we are not able to verify the insurance at the time that services are rendered we will not deny care, but please understand that it is your responsibility to verify the information with your insurance and that you are responsible for the charges that will incur and payments are expected in cash, credit card, or care credit on the same day services are rendered unless other arrangements are approved prior to the visit.
- We only accept the following as method of payments: Cash, CareCredit, Visa, Discover, MasterCard, American Express and Checks.

Payment Options

Your dental health and smile are important to us. We currently accept all PPO plans, and certain Medicaid plans. We also have payment programs designed to help you.

- We accept most PPO insurances and are required by our insurance contracts to collect co-pays and or deductibles at the time services are rendered. It is the responsibility of the care holder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested that the card holder verify coverage limits prior to the appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.
- If you have no insurance, we offer great discount and promotions that are sure to satisfy your dental needs. In many cases when payment in full cannot be made, we offer individualized budget agreement.
- CareCredit is accepted here and we can also help you with the application process. This card offers conveniently low monthly payment plans that allow you to pay over-time with no interest, annual fees or pre-payment penalties. This can help you with the co-payment plans, deductibles, and treatments not covered by your insurance. It can also help you with unexpected dental emergencies and able you to start treatment immediately. This is good both for insured and not insured parties.

Monthly Statements

If you have a balance on your account, a statement will be sent to you. The balance on the statement is due and payable when statement is issued and past due if not paid within 60 days. If the account becomes past due, we will take the necessary steps to collect this debt. All accounts sent to the collection agency will be reported to the Credit Bureau and you agree to pay all the collection fees and processing fees that apply. There is a charge of $25.00 for every returned check. If you have concerns or questions, please feel free to discuss them with the doctor or proper staff member to help you.

After reading and understanding, I request that services be performed and I agree to be responsible for any charges incurred. I understand that by signing this agreement, I agreed to all the terms and conditions contained herein, and the agreement will be in full force and effect.

I have read this Financial Policy as outlined above and understand that I am ultimately responsible for the charges incurred by my child/children as their legal guardian.

Signature

If Minor:
Parent/Guardian Name: _____
Parent/Guardian Signature: _____

Patient HIPAA Awareness

With my permission, Lago Family Dental may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lago Family Dental's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lago Family Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained bt forwarding a written request to the Privacy Officer.

With my permission, the office of Lago Family Dental may call my home or other designated locations and leave a message or a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Lago Family Dental may mail to my home or other designated location any items assist in the practice in carrying TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and/or Confidential.

With my permission, the office of Lago Family Dental may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Lago Family Dental restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions but if it does, it is bound by this agreement.

By signing this, I am allowing Lago Family Dental to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature

_____ _____

Print Name of Patient or Legal Gaurdian Date