Lifetime Family Dentistry

1 About You…

Today's Date: _____

Name: _____

Nickname: _____

☐ Male ☐ Female

☐ Single ☐ Married

Date of Birth: _____ Age: _____

Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____

Page/Mobile Phone: _____

Email: _____

May we contact you at work? ☐ Y ☐ N Best Time: _____

Employer: _____

Occupation: _____

Employer Address: _____

_____

Other Family Members at LFD: _____

_____

Whom may we thank for referring you? _____

Who was your former dentist? _____

Phone Number: _____

Last Visit: _____

2 Emergency Contact Info …

Emergency Contact: _____

Relation: _____

Cell Phone: _____

Work Phone: _____

Emergency Contact: _____

Relation: _____

Cell Phone: _____

Work Phone: _____

3 Account Information…

If other than yourself, please list the person responsible for the account: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Relationship: _____

Employer: _____

4 Financial Info…

Primary Dental Insurance: _____

Policy Holder: _____

Social Security #: _____

Date of Birth: _____

Group Number: _____

Subscriber ID#: _____

Telephone number: _____

Secondary Dental Insurance: _____

Policy Holder: _____

Social Security #: _____

Date of Birth: _____

Group Number: _____

Subscriber ID#: _____

Telephone number: _____

Health History

5 Health History...

Who is your personal physician? _____

Phone: _____

Please list any medications you are currently taking (including over the counter medicines).

_____ _____

_____ _____

_____ _____

_____ _____

Are you required to take premedication prior to receiving dental treatment due to artificial bones or a heart condition? ☐ Y ☐ N

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthesia	☐	☐	Metals
☐	☐	Aspirin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Sulfa
☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Latex			

Please list any other allergies: _____

_____

For Women Only:

Y	N		Y	N	
☐	☐	Are you pregnant?	☐	☐	Are you currently nursing?

_____ Weeks

Have you ever had any of the following disease or medical conditions?

Y	N		Y	N	
☐	☐	Alzheimers	☐	☐	Heart Murmur
☐	☐	Rheumatic/Scarlet Fever	☐	☐	Anemia
☐	☐	Anorexia/Bulimia	☐	☐	Arthritis
☐	☐	Epilepsy/Seizures/Fainting	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	Artificial joints
☐	☐	Low Blood Pressure	☐	☐	HIV/AIDS
☐	☐	Mitral Valve Prolapse	☐	☐	Kidney Problems
☐	☐	Blood Transfusions	☐	☐	Asthma
☐	☐	Heart Surgery/Pacemaker	☐	☐	Diabetes
☐	☐	Congenital Heart Defect	☐	☐	Emphysema
☐	☐	Physically Handicapped	☐	☐	Hearing Impaired
☐	☐	Difficulty Breathing	☐	☐	Heart Attack
☐	☐	Drug/Alcohol Abuse	☐	☐	Glaucoma
☐	☐	Psychiatric Problems	☐	☐	Shingles
☐	☐	Artificial Heart Valves	☐	☐	Stroke
☐	☐	Fever Blisters/Herpes	☐	☐	Tuberculosis
☐	☐	Cancer/Chemotherapy	☐	☐	Ulcers/Colitis
☐	☐	Radiation Treatments	☐	☐	Hemophilia
☐	☐	Severe/Frequent Headaches			

Is there anything else we should know about your health that we haven't covered in this form? _____

_____

6

I authorize release of any information relating to claims filed by Lifetime Family Dental.
I wish to assign benefits to Lifetime Family Dental, and understand that I am responsible for any co-payment and deductibles that my insurance does not cover. I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment/copayment is due in full at the time of treatment. I have received a copy of our Broken appointment policy. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____

Date: _____

Welcome to Lifetime Family Dentistry

Patient Portion is Due at Time of Service

We file Insurance as a courtesy to our patients.

- The patient portion we collect at the time of service is **only an estimate** and there **may be additional monies owed** after insurance pays.
- There are **no discounts** that can be given with Insurance or discount plans.

If you do not have insurance

- You can receive a **5% discount** on services provided if you pay with **cash or check**.
- You can receive a **10% discount** on services provided if you pay with **cash or check before your appointment day**.

We accept cash, checks, Care Credit, MC, Visa, Am. Express and Discover.

Thank you for trusting us with your dental needs!

_____ _____

Patient/Guardian Signature Date

Lifetime Family Dentistry

Lifetime Family Dentistry Appointment Agreement

Here at Lifetime Family Dentistry, we make every effort to respect your time and ask that you respect ours as well. The following plan ensures that your appointment is our highest priority.

- Sleep Dentistry appointment **fees are due in full** at the time medication is dispensed. This must be at least 48 hours prior to the appointment.

- If you are unable to keep a scheduled appointment, please notify the office **24 hours prior to that scheduled appointment.** We understand that sometimes emergencies happen so we do offer a courtesy allowance for one "no show" or cancelled appointment per year. After that has been utilized, you will be charged a **$50.00 fee per missed appointment**.

- Please notify the office **72 hours in advance to cancel appointment longer than 3 hours, otherwise a $50.00 fee will incur.**

These guidelines are set in place to ensure a smooth, comfortable and mutually respected relationship for everyone. Thank you from your dental family here at Lifetime Family Dentistry.

I, _____ have read and agree to this information.

(print name)

_____ _____

(patient/guardian signature) (Date)

Lifetime Family Dentistry

HIPAA Privacy Notice Consent Form

I understand and have been provided with Lifetime Family Dentistry's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. Lifetime Family Dentistry reserves the right to make changes to their Privacy Notice and revised copies are available. By signing this form I acknowledge that I have been afforded the opportunity to consider Lifetime Family Dentistry's Notice of Privacy Practices prior to signing this consent and making healthcare decisions. I also understand and agree to have my digital photo identification taken as part of my electronic health records.

I authorize Lifetime Family Dentistry to release medical and financial information, including any or all reports, records, bill for services rendered or opinions found in my dental chart, with respect to treatment to any alternative healthcare giver.

Lifetime Family Dentistry maintains patient records on paper, on microfilm and/or electronic media which may be accessible to any physician or healthcare provider participating in my current or future case. Dental records are disclosed according to applicable WI state and Federal laws and the provisions of this consent.

HIPAA AUTHORIZATION TO DISCUSS YOUR DENTAL AND MEDICAL INFORMATION:

_____ Patient or legal guardian only ****OR****

You may disclose my/their medical and dental information to:

_____ _____

Please Print Name **Relationship**

I acknowledge that I have received a copy of Lifetime Family Dentistry's Notice of Privacy Practice.

_____ _____

Signature of patient or legal guardian **Date**