Lago Vista Family Dentistry – Adult Form

Patient Information

Name: _____ Date of Birth: _____ Sex: ____ M ____ F
Address: _____ City: _____ Zip Code: _____
Phone #: _____ Additional #: _____ Email: _____
Are any family members patients of record? If yes, please list their names:_____
Whom may we thank for referring you to our office? _____

Emergency Contact Information

Relationship: _____
Name: _____ Date of Birth: _____
Address: _____ City: _____ Zip Code: _____
Work#: _____ Home #: _____
Cell #: _____ Other #: _____

Insurance Information

As a courtesy, we will accept assignment of benefit from most insurance companies. In order to do so, you must provide us with the following information.
Dental Insurance? _____ Yes _____ No If yes, please fill out the following information:
Name of person insured: _____ Relationship to patient: _____
Insured SSN/ ID#: _____ DOB: _____ Employer: _____
Insurance Company: _____ Phone #: _____ Group #:_____

Dental History

Date of last dental visit: _____ And reason for the visit: _____
Were radiographs captured? If yes, please list
_____
Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) _____
Have you had any of the following: _____ Cavities _____ Crooked teeth _____ Sensitive to hot/cold _____ Loose teeth
_____ Toothache _____ Sensitivity to sweets _____ Frequent headaches _____ Bad breath
_____ Bleeding gums _____ Discolored teeth _____ Jaw Pain/soreness _____ Orthodontic Treatment ____ Extractions
Do you have any of the following oral habits? _____ Finger sucking _____ Lip biting
_____ Teeth Grinding/Clenching _____ Excessive lip licking
Other:_____
How often do you brush? _____ How often do you floss? _____

Medical History

Name of Physician: _____
Phone #: _____ Are you in good health? _____ Yes _____ No
If no, please describe:
_____
Have you ever been hospitalized or had surgery? If yes, please list:
_____
Are you taking any kind of medication (prescription or over the counter)? Please list:
_____
_____
Have you ever had a reaction to or problem with anesthesia? If yes, please describe:
_____
Do you have any drug allergies? If yes, please list:
_____

Please circle yes or no for any of the following conditions you have had or now has:

Seasonal Allergies	Y/N	Impaired vision, hearing, or speech	Y/N
Asthma	Y/N	Convulsions/seizures/ Cerebral Palsy	Y/N
Sleep apnea/snoring/mouth breathing	Y/N	Hydrocephaly or placement of shunt	Y/N
Heart Disease	Y/N	Diabetes	Y/N
Heart Attack	Y/N	Head Injuries	Y/N
Heart Stent	Y/N	Thyroid problems	Y/N
Stroke	Y/N	Anemia/ blood disorders/ sickle cell disease	Y/N
Congenital heart defect/ Heart Murmur	Y/N	Excessive bleeding	Y/N
Rheumatic fever	Y/N	Blood transfusion	Y/N
High/Low Blood Pressure	Y/N	Cancer, tumors, or chemotherapy	Y/N
Cystic Fibrosis	Y/N	Tuberculosis exposure	Y/N
Frequent colds or coughs, or pneumonia	Y/N	Venereal Disease	Y/N
Jaundice/ Hepatitis/ Liver problems	Y/N	Glaucoma	Y/N
Acid reflux disease/Stomach ulcers/ intestinal problems	Y/N	Artificial Joints/Arthritis	Y/N
Frequent diarrhea, weight loss, eating disorder	Y/N	HIV/AIDS	Y/N
Bladder or kidney problems	Y/N	Other: _____	
FEMALE: Pregnant	Y/N	_____	

Authorization and Release

I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependent (s), including any balance not paid by my dental insurance company within 30 days of statement date. I understand that any unpaid balances may be sent to a collection company and I will be responsible for all collection charges. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or rental group any insurance benefits otherwise payable to me. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this dental office of any changes in my medical status. I authorize this office to release any information, including the diagnosis and records of treatment or examination rendered during the period of such dental care to third party payers and or other health practitioners.

Signature of Patient: _____ **Date:** _____
Printed Name: _____ **Witness:** _____

Lago Vista Family Dentistry

8008 Bronco Lane, Suite B, Lago Vista, TX 78645
P: 512-277-3311 F: 512-727-7943

Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of care and treatment.

• Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we will accept cash, check, visa, master card, discover and American Express. **You** are responsible for payment for services.

• Your insurance is a contract between you and your insurance company. As a courtesy, after your first initial visit and upon verification of coverage, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

• We are contracted with MOST dental insurance plans. If you are covered by one of these plans, we will bill your plan and will only require you to pay your estimated copayment at the time of service. Any remaining balance would be due upon receipt of our statement.

• All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered" or over what they deem "usual and customary charges"' you will be responsible for this amount. Payment is due upon receipt of statement from our office. If payment is not made upon receipt of our statement, we will no longer file your insurance. Therefore, we will expect payment in full at the time of service. We do honor some Discount Dental plans so please ask our front office staff to see if we accept your plan.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms.

Patient's Name: _____

Signature of Patient: _____ **Date:** _____

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Acknowledgement of Receipt of Notice of Privacy Practice

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient's Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other (Please provide specific details)

_____
_____
_____
_____

Employee Signature: _____

Date: _____

HIPPA Consent for Use / Disclosure of Health Information This form does not constitute legal advice and covers only federal, not state, laws.

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Appointment Consent

I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office on any changes in my medical status.

I understand that signing below I authorize the following procedures to be performed as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure.

X-rays and Examination
I understand that I will be receiving a dental examination from a state licensed dentist. I understand that x-rays may be taken of my teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Medical Photography Consent
I consent to digital photographs and x-ray images to be used exclusively within their medical record for the purpose of identification and dental treatment.

Drugs and Medication
I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions I have had.

I understand that all of the above treatments are the standard of care in dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments.

Optional Photography Consent
I consent to having my photo taken and displayed in the office as part of contests or bulletin boards.

☐ I consent ☐ I do not consent

I consent to having my photo taken and posted as part of online social media including, but not limited to the office website, Facebook and Google.

☐ I consent ☐ I do not consent

Patient's Name: _____ **Date:** _____

Signature of Patient: _____ **Witness:** _____