Lakewood Ranch Dental

New Patient Medical Form

Committed to Excellence
In *Dentistry*

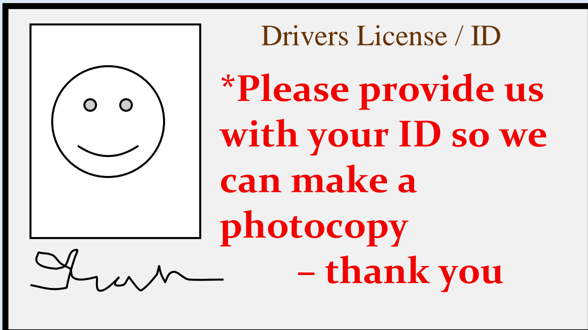
PATIENT INFORMATION

Patient Name:_______________________________________
SS# ____
DOB_______________ SEX: □Male □Female

Email: ______________________________________
Address:______________________________________
____

□Married □Widowed □Single
□Minor □Separated □Divorced
□Partnered for _____ years

Occupation:___________________________________
Employer: ____________________________________
Spouse's Name: ________________________________
Referred by: ___________________________________



Drivers License / ID

Please provide us with your ID so we can make a photocopy – thank you

DENTAL INSURANCE

Who is responsible for this account? _________________
Relationship to patient: ____________________________
Insurance Co. _____________________________________
Insurance phone #: _________________________________
Group # ____
Subscribers Name: _________________________________
DOB: ________________ SS# ______________________

Assignment and release
I certify that I and/or my dependent(s), have insurance coverage with _________________________________ and assign directly to Dr. ___________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

PHONE NUMBERS

Home ______________________________ Work __________________________ Cell ______________________________
Spouses # __________________________ Best time to reach you ________________ Best way to reach you __________
IN CASE OF EMERGENCY CONTACT
Name _______________________________________ Relationship _______________ Number ________________________

DENTAL HISTORY

Reason for today's visit:__________________
Former Dentist:___________________________
Phone #: ________________________________
Date of last dental visit: ___________________
Date of last dental x-rays: _________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	□Yes	□No
Bleeding Gums	□Yes	□No
Blisters on lip	□Yes	□No
Burning sensation on tongue	□Yes	□No
Chew on one side of mouth	□Yes	□No
Clicking or popping jaw	□Yes	□No
Dry Mouth	□Yes	□No
Fingernail biting	□Yes	□No
Food collection between teeth	□Yes	□No
Grinding teeth	□Yes	□No
Gums swollen or tender	□Yes	□No
Jaw or pain tenderness	□Yes	□No
Lip or Cheek Biting	□Yes	□No
Loose teeth or broken fillings	□Yes	□No
Mouth pain, brushing	□Yes	□No
Orthodontic treatment	□Yes	□No
Periodontal treatment	□Yes	□No
Sensitivity to hot and or cold	□Yes	□No
Sensitivity to sweets	□Yes	□No
Sensitivity when biting	□Yes	□No
Sores or growths in mouth	□Yes	□No

Tobacco Habit □Yes □No

How often do you floss? _______

How often do you brush? ______

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Health History

Physician's Name ________________________________ Phone # ____________________ last visit __________

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), pondimin (fenfluramine) and Redux (dexfenfluramine). □Yes □No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition			Condition			Condition		
Addiction	□Yes	□No	Cough, persistent	□Yes	□No	Mitral Valve Prolapsed	□Yes	□No
AIDS/HIV	□Yes	□No	Diabetes	□Yes	□No	Other Lung Disease	□Yes	□No
Anemia	□Yes	□No	Epilepsy	□Yes	□No	Pacemaker	□Yes	□No
Artificial Valves/joint	□Yes	□No	Fainting or dizziness	□Yes	□No	PreMed ♥	□Yes	□No
Asthma	□Yes	□No	Heart Disease	□Yes	□No	Radiation Therapy	□Yes	□No
Back Problems	□Yes	□No	Heart Murmur	□Yes	□No	Respiratory Disease	□Yes	□No
Bleeding abnormally	□Yes	□No	Hemophilia	□Yes	□No	Rheumatic Fever	□Yes	□No
Blood Disease	□Yes	□No	Hepatitis	□Yes	□No	Scarlet Fever	□Yes	□No
Cancer	□Yes	□No	Herpes	□Yes	□No	Sinus Trouble	□Yes	□No
Chemical Dependency	□Yes	□No	High Blood Pressure	□Yes	□No	Stroke	□Yes	□No
Chemotherapy	□Yes	□No	Liver Disease	□Yes	□No	Swelling of feet or ankles	□Yes	□No
Circulatory Problems	□Yes	□No	Low Blood Pressure	□Yes	□No	Thyroid Problems	□Yes	□No

MEDICATIONS

List any medications you are currently taking:
____
____
____

Pharmacy Name: ____________________________
Phone #: __________________________________

ALLERGIES

☐Aspirin
□Barbiturates (sleeping pills)
□Codeine
□Iodine
□Latex
□Local Anesthetic
□Penicillin
□Sulfa
□Other ______________
____

Getting to Know You…

Welcome to Lakewood Ranch Dental- We're glad you've chosen to be our patient! Let's get acquainted…

Hobbies & Interests: ____
Family? Kids? (ages): ____

Today's dentistry allows us to enhance your smile quickly and easily. How would you like your smile to look? (check what applies)
☐Straighter ☐Shorter ☐Longer ☐Wider ☐More Even ☐Replace Partials/Dentures
☐Close Spaces ☐More Even ☐Whiter ☐Replace Missing or Cracked Teeth ☐Other: ________________

Are you preparing for a special occasion? Wedding? Reunion? Vacation? Anniversary? If Yes, when? ____________________

To the best of my knowledge, the above information is correct. I understand that it is my responsibility to inform if I, or my minor child, ever have a change in health or insurance.

X____ Date ________________
Signature of Patient, Parent or Guardian or Personal Representative

Authorization & Release (relation to patient): □Self □Mother □Father □Guardian

Lakewood Ranch Dental
Insurance and Financial Policy

Committed to Excellence *in Dentistry*

At **Lakewood Ranch Dental**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

______ 1. Your dental benefits are based upon a contract made between your employer and an insurance company. We are the provider and not responsible to know your benefits with your dental carrier. We make every attempt to verify and explain your dental benefits to you as part of the exceptional customer service we strive to provide for our patients, but remember…… It is **YOUR** responsibility to know and understand your dental coverage before our office or any other dental office renders services. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

______ 2. We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

______3. We will bill your insurance as a courtesy. If insurance does not pay within **45days**, the balance will then be **your** responsibility. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU** and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

______4. **Lakewood Ranch Dental does require payment in full for your portion at the time of service**. We accept MasterCard, Visa, AMEX, Discover, Cash, and Checks. If you are in need of an extended finance option, we also work with CareCredit, who offers 3,6 or 12 month (interest free) or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

______5. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least a 48-hour** notice to avoid a cancellation fee.

______6. In the event of an emergency after regular business hours a $55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $125 after hours emergency fee.

______7. Privacy Policy: We are providing you with our Notice of Privacy Practices. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation as stated in the policy.

I agree with the above conditions.

Print Name: ____ Date: ____________

Patient/Parent or Guarantor Signature: ____