Patient Registration Information

(CONFIDENTIAL)

NAME:_____ DATE_____
First MI Last

HOME ADDRESS: _____

CITY: _____ST:_____ZIP:_____

BIRTHDATE: _____ E-MAIL:_____

HOME PHONE: _____ WORK PHONE:_____ CELL PH: _____

Do you prefer to receive calls at ____work _____home ____cell phone _____any

Social Security #_____ or Drivers License #_____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT:_____

Social Security #_____ or Drivers License #_____

Whom may we thank for referring you? _____

Emergency contact person: _____
Name and relationship

Phone #: _____

INSURANCE INFORMATION

Are you: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

PRIMARY **DENTAL INSURANCE**	***SECONDARY*** **DENTAL INSURANCE**
Name of Insured: _____	Name of Insured: _____
Birthdate: _____ SSN _____ OR ID # _____	Birthdate:_____ SSN _____ or ID # _____
EMPLOYER _____	EMPLOYER _____
Address: _____	Address: _____
_____	_____
INSURANCE CO: _____	INSURANCE CO: _____
Address: _____	Address: _____
_____	_____
Ins Co Ph #:_____	Ins Co Ph # _____

DENTAL HISTORY

Reasons for today's visit:_____

Former Dentisi:_____Address:_____

Phone#_____ Date of last dental care: _____Date of last x-rays:_____

Please circle yes / no if you have or have had problems with any of the following:

Bad breath	yes / no	Periodontal treatment	yes / no
Bleeding or sore gums	yes / no	Sensitivity to hot	yes / no
Clicking or popping jaw	yes / no	Sensitivity to cold	yes / no
Pain near your ears	yes / no	Sensitivity to sweets	yes / no
Food collection between teeth	yes / no	Recurring sores in or around the mouth	yes / no
Grinding teeth	yes / no	Swelling or lumps in mouth	yes / no
Clenching teeth	yes / no		
Loose teeth	yes / no	Do you have a removable dental appliance	yes / no
Broken fillings	yes / no		
Tender teeth to chew on	yes / no		

How often do you floss?_____ How often do you brush?_____

Have you ever had braces or orthodontic appliances? yes / no When?_____

INTEREST IN TOOTH WHITENING OR SMILE IMPROVEMENT PROCEDURES

Are you happy with the appearance of your teeth? yes / no Are you interested in whitening your teeth? yes / no

Are you interested in straightening your teeth? yes / no If you could change your teeth / smile, what would you change?_____

_____

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

LATE CHARGES

If I do not pay the entire new balance within 90 days of the monthly billing date, a finance charge of 1.5% (18% APR) on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is pre-payment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount for any future outstanding account balances.

Please sign here:_____Date:_____

Signature of Patient or parent, if minor

Lakeview Dental Center, SC

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

LAKEVIEW DENTAL CENTER

FINANCIAL POLICY

It is the intent of this office to inform our patients of their financial responsibilities to Lakeview Dental Center.

Payment on the day of service is expected. We ask that you arrive prepared to pay at the time of your appointment.

Day of Service: Treatment costs $800 or more will receive a cash savings of 3% if paid with credit card and 5% with cash or check.

Pre-pay: Patients that pre-pay for treatment of $800 or more will receive the cash savings of 3% or 5% depending on method of payment.

Financial arrangements should be made in advance of receiving treatment. When scheduling your appointment, please make us aware if you are interested in additional financing options that may be available to you. We can direct your call to our Business Coordinator who will be able to assist you with those arrangements. We also participate with Care Credit and would be happy to discuss those options and assist with the application process.

Flex Plans reimburse the Patient for healthcare expenditures. We prefer that our patients pay us day of service and submit their receipts for reimbursement. If you want to use your Flex Plan, we recommend that you discuss this in advance to clarify reimbursement policy.