



DENTAL HISTORY

Reasons for today's visit: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ 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<br>around the mouth   | yes / no |
| Grinding teeth                | yes / no | Swelling or lumps in<br>mouth               | yes / no |
| Clenching teeth               | yes / no | Do you have a<br>removable dental appliance | yes / no |
| Loose teeth                   | 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

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?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you
Pregnant/Trying to get pregnant?
Taking oral contraceptives?
Nursing?

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
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? 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



### *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.