Lifetime Dentistry
Cosmetic • Family • Implant

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient: _____ Today's Date: _____

Home Address: _____City/State/Zip: _____

Sex: M F Date of Birth: _____ Age: _____ SS#: _____

Please circle one: Single Married Divorced Widowed Name of Spouse: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Your Occupation: _____ Employer: _____

Parent or Guardian of Minor: _____SS# of Parent: _____

Person Responsible for Payment of Account: _____

Whom may we thank for referring you? _____

Email Address: _____

EMERGENCY INFORMATION: Name: _____ Relationship: _____

(Someone NOT living with you) Address: _____ Phone #: _____

Dental Insurance Information (Policyholder Information):

Name: _____ SS#: _____

Date of Birth: _____ Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Phone #: _____ Group #: _____

This information is strictly confidential and WILL NOT be released to anyone without your consent. It is important, for your safety that the Doctor knows about your Medical and Dental history. Please make sure this form is accurately completed to the best of your knowledge.

Patient Signature: _____Date: _____

General Medical History:

Do you currently have health problems? …… Yes/No

If yes, please explain _____

Are you under the care of a Physician? …… Yes/No

If yes, please explain _____

Have you been hospitalized within the last 5 years? …… Yes/No

If yes, please explain _____

Physician's Name: _____ Phone #: _____

Please list all medications that you are taking, including non-prescription drugs:

Have you ever had an allergic or adverse reaction to any of the following? If so, please circle:

Local Anesthetics	Penicillin	Ibuprofen
Topical Anesthetics	Erythromycin	Codeine
Nitrous Oxide	Sulfa	Latex
Iodine	Aspirin	Other: _____

Women Only:

Are you pregnant? …… Yes/No

If yes, what is the estimated due date?_____

Are you nursing? …… Yes/No

Do you take oral contraceptives? …… Yes/No

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Patient Dental History

Name of Previous Dentist and Location _____

Date of Last Dental Exam _____

(Please circle below as it applies and elaborate in the space provided as applicable)

Yes No Do your gums bleed while brushing or flossing?

Yes No Are your teeth sensitive to hot/cold liquid/foods?

Yes No Are your teeth sensitive to sweet or sour liquids/foods?

Yes No Do you feel any pain in any of your teeth?

Yes No Do you have any sores or lumps in or near your mouth?

Yes No Have you ever had any head, neck or jaw injuries?

(Have you ever experienced any of the following problems in your jaw?)

Yes No Clicking?

Yes No Pain in your joint, ear, side of face?

Yes No Difficulty in opening or closing or chewing?

Yes No Do you use tobacco?

Yes No Do you have any other condition, disease, or problem not contained herein that should be brought to the dentist's attention? Please explain:_____

_____.

Yes No Have you ever experienced trouble associated with any previous dental treatment? Please explain:_____

Yes No Do you have frequent headaches?

Yes No Do you clench or grind your teeth?

Yes No Do you bite your lips or cheeks frequently?

Yes No Have you ever had any previous difficulty with extractions?

Yes No Have you ever had any prolonged bleeding following extractions?

Yes No Have you ever had any orthodontic treatment (braces)?

Yes No Do you wear dentures/partial dentures? If yes, previous date of placement:_____

Yes No Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

Yes No Do you like your smile? If no, please explain:_____

_____

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Do you currently or have you ever had any of the following conditions? Please **circle** as it applies:

Heart Trouble	Hepatitis A (infection)	Asthma
Heart Attack	Hepatitis B (serum)	Emphysema
Open-Heart Surgery	Hepatitis C	Autoimmune Disease
Tuberculosis (TB)	Liver Disease	Multiple Sclerosis
Heart Pacemaker	Kidney Disease	Shortness of Breath
Artificial Heart Valve	Bleeding Disorder	Sinus Trouble
Mitral Valve Prolapse	Anemia	Head/Neck Injury
Congenital Heart Defect	HIV	Gout
Rheumatic Fever	AIDS	Arthritis
Rheumatic Heart Failure	Drug Addiction	Seasonal Allergies
Angina (chest pain)	Alcoholism	Steroid Therapy
Congestive Heart Failure	Diabetes	Glaucoma
Swollen Ankles	Ulcers	Tumors/Growths
High Blood Pressure	Fainting Spells	Cancers
Low Blood Pressure	Epilepsy/Seizures	Chemo/Radiation
Artificial Joint/Implant	Stroke	Organ Transplant
Thyroid Problem	Sexually Transmitted Disease	Marked Weight Change

Other Medical Problems:

_____

Patient Signature: _____ Date: _____

Insurance Consent

As a courtesy, Lifetime Cosmetic and Family Dentistry will file your insurance claim and assist in collecting from the insurance company. However, Lifetime Cosmetic and Family Dentistry does not render services on the assumption that our charges will be paid by the insurance company. The "patient portion" *is only an estimate,* and in the event that the insurance company pays less than the estimated amount, **you are responsible for the unpaid portion.**

We would also like to inform you that most (but not all) insurance companies allow the benefit of amalgam (silver/mercury) fillings instead of composite fillings (tooth colored) and the benefit of full cast crown (metal/gold) instead of porcelain fused to high noble metal crowns on posterior (back) teeth. The cost difference between the two is usually minimal but please be aware, **you will be responsible for the amount that your insurance does not cover.** If your insurance does downgrade, we will provide you with the estimate based on the adjusted fee.

Patient Signature: _____ Date: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review in the reception area.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is available from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

_____**This summarizes our policy here at Lifetime Dentistry.** Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's, etc) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctors desk, examination room ect. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

_____**We send out reminders to our patients.** We do this by one or more of the following: e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatment that you may need. We may send you other communications informing you of changes to office policy and new technology that you might find valuable and informative. We also may send out newsletters or special promotions that we are offering.

_____You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided.

_____You give us permission to remind you to take pre-medication prior to appointment, if applicable.

_____You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.

_____You understand and agree to inspections of the office and review of document which may include PHI by government agencies or insurance payers in normal performance of their duties.

_____You give us permission to take photograph of before and after your dental treatment, and I agree that Lifetime Dentistry will be the sole and exclusive owner of such photographs.

_____We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.

Please list any individuals whom you authorize Lifetime Dentistry to discuss your dental and financial needs with.

Name _____ Relationship _____ Phone number _____

Name _____ Relationship _____ Phone number _____

Name _____ Relationship _____ Phone number _____

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future updates to this policy.

_____

Signature **Print Name** **Date**

Patient Consent Form
Lifetime Cosmetic and Family Dentistry

I understand that, under the Health Insurance Portability & Accountability Act OF 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information have informed me. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

Patients name: _____ Date: _____

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Appointment Cancellation Policy

At *Lifetime Cosmetic and Family Dentistry* we thrive on the value of dental care that each patient receives with every appointment. Our staff spends time meticulously preparing for your appointment by sterilizing, organizing and arranging your dental treatment room prior to your arrival. Our stringent policy allows us **to schedule one patient at a time, rarely double booking patients as Dr. Austin and Dr. Kim place a high value on quality time with each patient.**

If you are unable to keep your reserved appointment time, we require that you call our office **at least 24 hours** in advance. Failure to do so will result in **a $25.00 broken appointment fee** for every hour of your scheduled treatment time that must be paid upon the scheduling of your next appointment**. Patients who consistently cancel will be double booked.** Patients who miss their appointments will be dismissed from the practice upon their third offense. We are confident that you are courteous and respectful enough to comply with our appointment policy. Thank You.

_____ _____

Patient/Guardian signature Date