PATIENT INFO. **DATE**_____ ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **Dr.**

Patient Name: _____ **Social Security** #:_____

Date of Birth:_____ ☐ Child ☐ Single ☐ Married ☐ Other ☐ Male ☐ Female

Address:_____

City:_____ State:_____ ZIP:_____

Home Phone:_____ **Work Phone**:_____ **Cell Phone**_____

Nearest Relative not in your home _____**Phone #**_____

Patient Employer or School_____ Occupation:_____

Drivers License # _____

E-mail Address:_____

Who Referred You? ☐ Phone Book ☐ Newspaper ☐ Sign ☐ Postcard ☐ Friend Name:_____

☐ Internet surfing, which website:_____

DENTAL HISTORY

Have you been having any specific problems? ☐ Yes ☐ No Describe:_____
Last dental visit?_____ Purpose:_____ Last complete exam:_____

Has fear of discomfort kept you from regular visits? ☐ Yes ☐ No

How do you describe your dental health? ☐ Good ☐ Fair ☐ Poor

Do you feel you have active dental disease? Decay? ☐ Yes ☐ No Gum Disease? ☐ Yes ☐ No

Home Care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No Water Jet? ☐ Yes ☐ No Other:_____

Do your gums ever bleed? ☐ Yes ☐ No How often?_____

Do you like your smile? ☐ Yes ☐ No _____

Do you snore? ☐ Yes ☐ No _____

Have you been diagnosed with Sleep Apnea? ☐ Yes ☐ No

If so can you tolerate your CPAP Machine? ☐ Yes ☐ No ☐ N/A

Would you like information regarding our Bleaching Special? ☐ Yes ☐ No

Are you interested in straightening your teeth without braces? ☐ Yes ☐ No

MEDICAL HISTORY **Please answer each question and mark yes or no where indicated.**

Name of your Physician:_____ **If you do not have a physician, please write "none".**

Phone Number:_____(**Please call us back w/ phone number**) Last Exam:_____

(Women) Are you pregnant? ☐Yes ☐ No Expected delivery date_____ Are you taking birth control? ☐Yes ☐No

Are you under a doctor's care now? ☐ Yes ☐ No If so, for what reason?_____

Are you taking any pills, medications, or drugs? ☐ Yes ☐ No Please list: _____

_____

Do you have or have you ever been treated for any of the following? **Please check all that apply.**

☐ AIDS/HIV	☐ Asthma	☐ High/Low Blood Pressure	☐ Pacemaker
☐ Alcoholism	☐ Attention Deficit Disorder	☐ High Cholesterol	☐ Radiation/Chemo Treatment
☐ Allergy to medications	☐ Blood Disease	☐ Hormone Replacement Tx	☐ Respiratory Problems
☐ Allergy (anesthetic)	☐ Cancer	☐ Kidney Trouble	☐ Rheumatic Fever
☐ Allergy (other) _____	☐ Diabetes	☐ Latex Allergy	☐ Seizures
☐ Angina/Chest Pains	☐ Dizziness/Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Anti-Depression Treatment	☐ Epilepsy/Convulsions	☐ Migraines	☐ Stroke
☐ Arthritis (Type)_____	☐ Excessive Bleeding	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Artificial Heart Valves	☐ Heart Disease	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Artificial Joints	☐ Heart Murmur	☐ Nervous Disorders	☐ Tumors
☐ Aspirin Tx/Blood Thinner	☐ Hepatitis	☐ Osteoporosis	☐ Ulcer

Do you use any type of tobacco product? None Cigarettes Cigar Pipe
Have you used any street/illicit drugs in the past? Y N List: _____
Currently use street/illicit drugs? Y N List: _____

To the best of my knowledge, all of the above dental and medical history answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail. _____

Responsible Party or Primary Insurance Information: Please notify front desk if there is secondary dental insurance.

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent
Responsible Party's name or **Policy Holder's name** _____

Social Security #:_____ Drivers License #_____

Date of Birth:_____

Address:_____ ☐ Single ☐ Married ☐ Other _____

City:_____ State:_____ ZIP:_____ ☐ Male ☐ Female

Home Phone:_____ **Work Phone**:_____ **Cell Phone** _____

Employer:_____ Occupation:_____

Address:_____ City:_____ State:____ ZIP:_____

Insurance Company Name:_____ Insurance Group No._____

Insurance Plan Phone:_____ Effective Date: _____

Insurance Plan Address:_____ City:_____ State:____ ZIP:_____

Secondary Dental Insurance _____

Insurance Group No: _____ Insurance Plan Phone:_____

Insurance Plan Address:_____ City: _____ State:____ Zip:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent
Responsible Party's name or **Policy Holder's name** _____

Social Security #:_____ **Date of Birth:**_____

Payment Policies

- Fees are determined by the services required. You may discuss any fees with our Office Staff.
- **All estimated co-pays and deductibles are due at the time of service.**
- Your account, if any balance is due after insurance pays, is **due by the 30th** of the month**. A $5.00 late fee will incur if received 3 days late**, as well a finance charge to any past due accounts.

Payment Options:

For Crowns ▸ **Payment of One-Half Down at the First Appointment and the Balance at Cementation. For Bridges, Dentures and Partials** ▸ **Payment of One-Half Down at the First Appointment and the Balance at try-in visit.**

- **Six Months Same as Cash: Balance MUST be at least $600.00**
- **Twelve Months Same as Cash: Balance MUST be at least $1500.00**

Through Care Credit for our patients who qualify.

Extended payment plans are available (not interest free). (If interested ask for an application.)

- **Due at the time of service:** All co-payments will be collected at the time of service.
- **We accept cash, checks (ran thru Telecheck with a valid license), credit and debit cards.**

Collections Policy

If a collection agency is used to recover any unpaid balance due to us, **the responsible party is liable for all charges** incurred**. You will be charged $25.00 for a returned check with insufficient funds. $10.00 for each time check is re-processed.**

APPOINTMENT CANCELLATION POLICY/BROKEN APPOINTMENTS/OR *LATE FOR APPOINTMENTS/DISMISSAL OF PATIENT

Your appointment has been reserved exclusively for you. Please provide ample notification if you need to change your appointment. Your appointment time may be appreciated by another patient**. Failure to give 24 hours notice will result in a charge of $45.00/per hour of scheduled time. *You will be charged $45.00 and rescheduled if you are 15 minutes late. PLEASE RESPECT OUR TIME AND THE PATIENTS SCHEDULED AFTER YOU. You will be dismissed as a patient if you consistently break appointments or consistently arrive late for appointments.**

Consent for Services After my exam, I authorize the doctor to perform the necessary treatment as needed. Any major treatment ie; root canals, oral surgery, implants will be discussed and an additional consent will be signed. I authorize the release of any information relating to dental treatment to third party payers and/or other health practitioners for myself or my dependents by Lakeland Hills Dental. I authorize my doctor to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for my dependents or myself. **I understand that all insurance payments will be made directly to the doctor, unless otherwise specified by me.**

Records and X-rays Illinois Dental Practice Act(225 ILCS 25/50). Every dentist shall make a record of all dental work performed for each patient. The record shall be made in a manner and in sufficient detail that it may be used for identification purposes. Dental records required by this section shall be maintained for 10 years. Dental records required to be maintained under this section, or copies of those dental records, shall be made available upon request to the patient or the patient's guardian, provided that the reasonable cost of reproducing the records has been paid by the patient or the patients guardian.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENTS.
I ALSO CONFIRM THAT THE INFORMATION I HAVE PROVIDED IS THE BEST TO MY KNOWLEDGE AND TRUE.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN:_____ DATE:_____