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?______________________

What would you like to change the most in the appearance of your teeth? ______________

Are your teeth all in alignment (straight)? ______________________

Do you have spaces that you don't like? ______________________

Do you like the color of your teeth? ______________________

Do you like the shape of your teeth? ______________________

Are there old fillings or dental work you don't like looking at? ______________

How would you like your teeth to look? ______________________

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:_____________