WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can assist you with your dental needs.

PATIENT INFORMATION :

Today's Date_____ Birth Date _____Patient Social Security # _____

Patient Name _____
(Last Name) (First Name) (Middle Initial)

Street Address_____

City _____ State _____Zip_____

Patient Home Phone _____ Patient Work Phone _____Cell Phone _____

Email Address_____

Occupation _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer _____ Employer Phone _____

Employer Address _____

IN CASE OF EMERGNECY CONTACT:

Name _____ Relationship _____

Emergency Home Phone _____ Emergency work Phone _____

Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE:

Individual responsible for this account_____
(Last Name) (First Name) (Middle Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone_____

City _____ State _____ Zip_____

Responsible Party Employed by _____ Business Phone _____

Insurance Company _____ Insurance Address_____

Subscriber I.D.# _____ Group # _____

ADDITIONAL DENTAL INSURANCE:

Insured Individual's Name _____
(Last Name) (First Name) (Middle Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone_____

City _____ State _____ Zip_____

Responsible Party Employed by _____ Business Phone _____

Insurance Company _____ Insurance Address_____

Subscriber I.D.# Group #

ASSIGNMENT AND RELEASE:

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Dental History

Patient Name_____Date_____

Previous Dentist_____ How Long_____

Most recent dental exam _____ Most Recent Dental x ray_____ Most recent dental treatment_____

How often do you have your teeth cleaned? 3 mo_____4 mo_____6mo_____1year or longer?_____

Please answer YES or NO to the following:

1. Unhappy with the appearance of your teeth .....YES NO
2. Unfavorable dental experiences .....YES NO
3. Dental fears .....YES NO
4. Problems with effectiveness or bad reactions to dental anesthetic ...YES NO
5. Orthodontic treatment (braces) when .....YES NO
6. Periodontal (gum) treatment .....YES NO
7. Bleeding gums .....YES NO
8. Avoid brushing any part of your mouth .....YES NO
9. Part of your mouth is sensitive to temperature.....YES NO
10. Sore teeth .....YES NO
11. A burning sensation in your mouth.....YES NO
12. Difficulty swallowing.....YES NO
13. An unpleasant taste or odor in your mouth.....YES NO
14. Dry mouth, throat, or eyes.....YES NO
15. Jaw problems (temporomandibular joint).....YES NO
16. Difficulty opening your mouth widely.....YES NO
17. Stiff neck muscles.....YES NO
18. Awaken with an awareness of your teeth or jaws.....YES NO
19. Tension headaches.....YES NO
20. Clench or grind your teeth.....YES NO
21. Jaw clicking or popping.....YES NO
22. Lost any teeth.....YES NO
23. Do you sweat or tremble a lot during examination.....YES NO
24. Do strange people or places make you afraid.....YES NO

Supplemental Denture History:
If you are wearing a partial or complete artificial denture, please complete the following:

YES NO Has your present denture been relined? When_____
YES NO Is your present denture a problem? Describe_____
YES NO Satisfied with the appearance?_____
YES NO Satisfied with the comfort?_____
YES NO Satisfied with the chewing ability?_____
When did you receive your first partial or complete denture?_____
How long have you worn your present denture? _____

Patient's Signature_____Date_____

Doctor's Remarks_____

Doctor's Signature Date

Lakepoint Dental
4720 Elk Grove Blvd., Suite 170, Elk Grove, CA 95758
Telephone (916) 691-9191 – Fax (916) 691-9195 – website: www.lakepointdental.com

PATIENT HEALTH HISTORY

Your Name: _____ Date of Birth: _____
Physician's Name: _____ Physician's Phone: _____ Medical/Kaiser # _____

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

(Please Circle)

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 _____
Do you, or have you ever taken Phen-Fen or Redux?	YES	NO	
Do you or have you ever taken **Fosamax** or similar medication?	YES	NO	
Do you smoke or use tobacco?	YES	NO	
Do you use controlled substances?	YES	NO	

WOMEN: Are you Pregnant/ Trying to get pregnant? *(please circle)* YES NO Taking Oral Contraceptives? *(please circle)* YES NO Nursing? *(please circle)* YES NO

Are you allergic to any of the following? *(please check all that apply)*

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

☐ Other If yes, please explain _____

Please list all medications you are currently taking:

_____ reason _____ _____ reason _____
_____ reason _____ _____ reason _____

Do you have, or have you ever had, any of the following: ***(please circle)***

AIDS / HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Disease	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 / 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	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Disease		
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Stroke	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Lung Disease	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Mitral Valve Prolapse	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Osteoporosis	Yes	No	Tonsilitis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Tumors/Growths	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Ulcers	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatment	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	Yellow Jaundice	Yes	No

(please circle)

Have you ever had any serious illness not listed above? Yes No If yes, 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.

Patient's Signature _____ Date _____

Dentist's Signature _____ Date _____

Lakepoint Dental

Thank you for choosing Lakepoint Dental as your dental care provider. In our continued commitment to provide the highest quality dental care available to all our patients and to have those services comfortably affordable

Acknowledgement of receipt of Notice of Privacy Practices

_____(*initials*)** I hereby acknowledge that I have been given the right to review the office's Notice of Privacy Practices. (HIPAA), a copy of this notice was available during registration.

Acknowledgement of receipt of Dental Materials Facts Sheet

_____(*initials*)** I hereby acknowledge that I have been given the right to review the office's Dental Materials Facts Sheet, copy of this notice was available during registration.

Authorized Family Members

I consent for the following family members to call on my behalf and discuss about: (if none, leave blank)

□ Only financial matters.

□ Only appointments, scheduling, and treatment

□ All matters – financial, appointments, and clinical.

Name _____Relationship_____

Name _____Relationship_____

Name _____Relationship_____

<u>This consent can be withdrawn at any time.</u>

Cell Phone

I consent to the dental practice using the cellphone number I have provided to:

□ Call- I consent to receive calls from the dental practice regarding appointments, treatment, insurance, and my account
□ Text- I consent to receive texts from the dental practice regarding appointments

_____ _____

Signature (Patient/Representative Party- state relation) Date

Release and Utilization of Dental Records

Lakepoint Dental is hereby authorized to utilize and/or release all or portion of my dental records or other material (including radiographs, intraoral pictures, clinical records) in connection with clinical evaluation, co-diagnosis, referrals to specialists, and prescriptions to a pharmacy.

_____ _____

Signature (Patient/Representative Party- state relation)** Date

** YOU MAY REFUSE TO SIGN THIS SECTION

For office use only: We attempted to obtain written acknowledgement for receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because: □Individual refused to sign □Communication barrier prohibited obtaining acknowledgement □An emergency situation prevented us from obtaining acknowledgement □Other (please specify)_____

Lakepoint Dental – Financial Contract

Thank you for choosing Lakepoint Dental as your dental care provider. In our continued commitment to provide the highest quality dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment:

- *Cash, Check, Visa/Mastercard/Amex, Care Credit, MORE Mastercard, Denefits (Please ask staff for details)*
- *A $50 NSF fee will be charged for all returned checks*

The following is a statement of our financial policy, which we require you to read and sign prior to treatment:

- **Full Payment is due at the time of scheduling your next appointment or before your services are rendered.**
- A minimum deposit of $50 is required to schedule an appointment during extended hours. The deposit will be forfeited if 2 business day notice is not provided. We have found that most patients would prefer to make their payment in advance to reserve an appointment rather than wait on the possibility that other patient's will move their appointments.
- To make appointments flow seamlessly and have no waiting times, our new policy requires all treatment plans signed and all questions or concerns regarding insurance or treatment answered *prior* to scheduling an appointment.
- Our office accepts most insurances and we help bill your insurance for payments once services are completed, however patient payment is due when reserving an appointment.
- You will be billed in full for any services that your insurance plan deems to be a non-covered service or any balance due after we have received payment from your dental insurance carrier.
- We will not be sending billing statements going forward to focus our time serving our patients better and to be a truly paperless office.
- Your account will be charged 1.5% interest per month, or 18% per year, on outstanding balances over 60 days from the date of service.
- Should any account become delinquent, over 90 days, the Responsible Party will assume collection costs and reasonable legal fees.

Appointments

All of our patients are seen on appointment basis. The appointment time is reserved especially for you. In most cases, the procedure you are scheduled for requires that a definite amount of time be set aside with the dentist. If you arrive **10 minutes past your scheduled appointed time, your treatment may be changed in order to accommodate the remaining time available or if schedule does not permit, the appointment will be rescheduled.**

- Our office days are Monday through Thursday, extended hours are available on Monday Evenings, Fridays and Saturdays by appointment. Please help us serve you better by keeping your scheduled appointments. If, for any reason, you should need to change your appointment during normal office hours, there will be no charge **provided you give a 2 Business days' notice. The charge for missed appointments is $50 per patient per hour of blocked time.**

Sedation/Extended hours/Specialist

If you choose to schedule an appointment during our extended hours, for sedation, or to see our specialist, you are required to pay your portion at the time the appointment is scheduled. If you do not show for your appointment or do not give **a 2 Business days' notice,** you forfeit the sedation/specialist deposit payment you have made along with a missed appointment fee of $100 per patient per hour.
For patients choosing sedation, please refer to our sedation packet for more information regarding policies.

Information Changes

To ensure our records are current, please notify us of any changes related to health, telephone numbers, employer or insurance information as they occur. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience. Help us serve you better.

_____ _____

Signature (Responsible Party) Date

_____ _____

Signature of Staff Member Date

Notice about Insurance Benefits

We will, as a courtesy, help process the insurance claims in our office for your services rendered on your behalf. We are committed in helping you with insurance billing, however **please remember your insurance is a contract between you, your employer, and the insurance company: therefore, we cannot guarantee coverage.** If you have a specific question regarding your coverage, please contact your insurance company directly. We require that you familiarize yourself with your dental benefits. Not all services are covered benefits in all contracts: therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated and presented to you regardless of your dental insurance benefits, deductibles, limitations, or maximums. In the event payment is not received from your insurance company within 60 days from the date of service, you are responsible for the balance in full.

Understand that we will be happy to help you make the most of your dental benefits and assist you in understanding them. When a claim is submitted and benefits are determined, we have little influence over coverage.

I understand that I am responsible for my balance with Lakepoint Dental, including under the following circumstances but not limited to:

- A deductible was applied and will be collected alongside your patient co-pay
- A denied procedure due to plan limitations
- Not eligible for insurance at the time services are rendered
- Benefits have reached maximum allowance from insurance plan for the year
- Procedure covered at different co-insurance rate(percentage)
- Insurance benefits are less than what was indicated on the schedule of benefits provided by your insurance plan
- Waiting period instilled by the insurance plan for new enrollees, which were not disclosed
- Deductible applies to preventive services
- I prevent or delay payment by not complying with the request for any additional information or signatures requested
- I do not complete my treatment and it results in non-payment from the insurance company
- I receive an insurance check instead of the office for services rendered and do not send it to Lakepoint Dental
- A pre-authorization is not a guarantee of benefits from your insurance plan and payment may change after services are rendered.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience. Help us serve you better.

I have read and understand that I am financially responsible for all charges not paid by my insurance plan.

_____ _____

Signature (Responsible Party) Date

_____ _____

Signature of Staff Member Date