We Welcome You To

Lifetime Dental Care

Patient Information (CONFIDENTIAL)

Date ____________

Age ____________ Soc. Sec. # ____________

Name ____________ Nickname ____________ Birthdate ____________ Home Phone ____________

Address ____________ City ____________ State ________ Zip ________

Check Appropriate Box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated Sex ❑M ❑F

If Student, Name of School/College ____________ City ____________ State ______ ❑Full Time ❑Part Time

❑ Patient's or ❑Parent's Employer ____________ Work Phone ____________

Business Address ____________ City ____________ State ________ Zip ________

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

Referred by: ❑TV ❑Radio ❑Phone Book (specify) ____________

❑Friend/Family ____________

Person to Contact in Case of Emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this account ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Driver License # ____________ Birthdate ____________

Employer ____________ Work Phone ____________ SS# ____________

Is this Person Currently a Patient in our Office? ❑Yes ❑No

Dental Insurance Information

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Address of Employer ____________ City ____________ State ________ Zip ________

Insurance Company ____________ Group # ____________ Policy/ID # ____________

Ins. Co. Address ____________ City ____________ State ________ Zip ________

How Much is Your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

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.

Date of last medical exam: ____________ What was this exam for? ____________

Are you currently receiving care? ❑Yes ❑ No

If yes, nature of care: ____________

Please list names and phone numbers of the physicians/chiropractors currently providing your care:

1. ____________
2. ____________
3. ____________

Please list any medications or supplements you are taking, the dose, and how often:

1. ____________ 2. ____________

3. ____________ 4. ____________

5. ____________ 6. ____________

COMPLETE OTHER SIDE OF FORM PLEASE

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PATIENT'S NAME ____________________ If (yes) please list

Have you been hospitalized in the last 5 years? .... ☐Yes ☐No ____________________

Have you ever had a serious head or neck injury?................ ☐Yes ☐No ____________________

Do you take, or have you taken, Phen-Fen or Redux?........... ☐Yes ☐No ____________________

Abnormal Blood Pressure ☐Yes ☐No If yes what was last reading? _____/_____

Do you consume grapefruit juice, grapefruits, or grapefruit extract ☐Yes ☐No

Are you taking Tagament (Cimetidine)? ☐No ☐Yes How often?____________________

Do you take Antacids? ☐No ☐Yes How often?____________________

Weight ____________________

Do you take any herbal supplements/medicines? ☐No ☐Yes ____________________

Have you been diagnosed or treated for Sleep Apnea ☐No ☐Yes ____________________

Are you on a restricted diet? ☐No ☐Yes ____________________

How many meals/snacks do you have per day? ____________________

Do you have any Food Allergies? ☐No ☐Yes ____________________

Amount of Sugar in your diet (pop, candy, gum, juice, snoballs) ☐None ☐Slight ☐Moderate ☐High

Do you smoke or use tobacco? ☐No ☐Yes Number of packs/cans per day ____________________

Do you use controlled substances? ☐No ☐Yes What ____________________

Have you had joint or heart valve replacement, pins, screws, heart murmur? ☐No ☐Yes

Have you been told to take antibiotics before dental treatment? ☐No ☐Yes

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

Are you allergic to the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Valium or other sedatives ☐Other__________

Do you have, or have you had, any of the following?

☐ AIDS/HIVPostive	☐ Cold Sores/Fever Blisters	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Abnormal bleeding from cuts	☐ Congenital Heart Disorder	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Slow-Healing Mouth Sores
	☐ Convulsions	☐ Heart Murmur	☐ Lung Disease	☐ Spina Bifida
☐ Alzheimer's Disease	☐ Cortisone Medicine	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Sore/Enlarged Lymph Nodes
☐ Anaphylaxis	☐ Diabetes	☐ Heart Trouble/Disease	☐ Other Infections	☐ Stomach/Intestinal Disease
☐ Anemia	☐ Drug Addiction	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Stroke
☐ Angina	☐ Easily Winded	☐ Hepatitis A	☐ Parathyroid Disease	☐ Swelling of Limbs
☐ Arthritis/Gout	☐ Emphysema	☐ Hepatitis B or C	☐ Previous Biopsies	☐ Thyroid Disease
☐ Artificial Heart Valves	☐ Epilepsy or Seizures	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Artificial Joints	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Radiation Treatment	☐ Tuberculosis
☐ Asthma	☐ Excessive Thirst	☐ HIV Infection/AIDS	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Blood Disease	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Recurrent Illnesses	☐ Ulcers
☐ Blood Transfusion	☐ Frequent Cough	☐ Hypoglycemia	☐ Renal Dialysis	☐ Unintentional Weight Loss/Gain
☐ Breathing Problem	☐ Frequent Diarrhea	☐ Irregular Heartbeat	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bruise Easily	☐ Frequent Headaches	☐ Joint Replacement	☐ Rheumatism	☐ Yellow Jaundice
☐ Cancer	☐ Frequent Tired	☐ Kidney Problems	☐ Scarlet Fever	
☐ Chemotherapy	☐ Genital Herpes	☐ Latex Sensitivity	☐ Shingles	
☐ Chest Pains	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease	

Have you ever had any serious illness not listed above? ☐Yes ☐ No Comments:____________________

Patient Dental History

Name of Previous Dentist and Location ____________________ Date of Last Exam ____________________

	Yes	No
1. Do your gums bleed while brushing or flossing?.............	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?........	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods? .	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth? .	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following .... problems in your jaw		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you ever had any orthodontic treatments?	☐	☐
14. Do you wear dentures or partials? .... If yes, date of placement____________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge, and the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby grant permission to the staff of this office for the administration of such medications and anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for dental care. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. ***I AGREE TO BE RESPONSIBLE FOR THE PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON MY DEPENDENTS AT THE TIME OF SERVICE.***

*SIGNATURE*____________________ *Date*____________________

Patient / Parent / Guardian

Payment Arrangement

Thank you for choosing Lifetime Dental Care as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service available. To help reduce administrative costs and keep our fees as low as possible, we respectfully request payment to be made at the time that you or your family members receive treatment. Please indicate below the method of payment you intend to use.

My preferred payment option is:

_____ Cash/check
_____ Major credit card (Visa, MasterCard or Discover)
_____ **Amounts over $300.00 we offer a 5% courtesy adjustment for cash/check payment in full before treatment begins**
_____ For treatment amounts over $300.00 please inquire about the possibility of an extended payment plan through Care Credit or visit www.carecredit.com

Note for patients with dental insurance

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually estimate the amount you will owe. This is called your co-payment. When treatment is delivered to you or your family members, your co-payment is expected at that time. If you insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

Signature: ______________________________ Date: ______________

Lifetime Dental Care staff members will always recommend the highest standard of treatment. Our primary concern is your overall health. If you wish, we will gladly discuss alternative treatments or phases to work within your financial budget. We recognize that every patient will have different situations and, ultimately, it is up to you to decide the importance of your dental health and whether you wish to accept the recommended treatment. If you have any questions regarding these policies or financial arrangements, please contact our financial coordinator about your concerns.

Reduction not available to those with BCBS or Delta Dental

Lifetime Dental Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Social Security Number: ____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jana Lowe

Telephone: 785-625-7969 Fax: 785-625-4441 E-mail: jlowe@lifetimedentalcare.com

Address: 2701 Sternberg Drive, Hays, KS 67601

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you f you revoke this Consent.

I have had full opportunity to read and consider the-contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

SIGNATURE:

Signature: ____

Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT LET US KNOW IF YOU WANT A COPY

Include completed Consent in the patient's chart.

APPOINTMENT CANCELLATION POLICY

I, ______________________________________ understand that it is my responsibility to kindly call and cancel or reschedule any appointment. I will do so 48 hours prior to my scheduled appointment, or I will leave a message on the office answering machine if the office is closed.

If an appointment is missed without calling in to cancel or reschedule I agree to pay a fee of 25% of my scheduled appointment. If three appointments are missed without appropriate notice, this office will no longer be able to reschedule you for further appointments.

I have read and understand my obligation as a patient/parent/patient representative to this office in regards to Lifetime Dental Care's appointment cancellation policy.

____
Signature

____
Date

ACCEPTING INSURANCE ASSIGNMENT POLICY

Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "CONTRACT" is between the patient and the insurance company, the account thereby being the responsibility of the patient for any amount not paid by the insurance company. Below are statements of our policies governing insurance claims:

1. With the exception of Delta Dental Insurance, our office does bill the insurance company. Therefore it is necessary for the patient to have all of the insurance information filled out completely. If this is not completed, we will not be able to appropriately bill the insurance company, and the responsibility for payment then becomes that of the patient. There are no exceptions to this policy.

2. We require our patients to sign an "Authorization to pay the Doctor" form located on the bottom of page 2 of the Patient Information form (or any other necessary assignment documents required by your insurance company). By doing so, the insurance company will make payments directly to our office.

3. The patient will pay the co-payment (the amount not covered by the insurance company) and applicable deductible as agreed upon during the financial consultation is due on date of service. The insurance company will never guarantee payment – they only give us an estimated fee amount. The patients portion may be more than the estimate given to us by the insurance.

4. Insurance payments ordinarily are received within 30 to 60 days from the time of billing. **If a patients insurance company has not made a payment to our office within 90 days,** we may request that the patient pay the balance due, and then seek reimbursement from the insurance company when and if it pays.

5. Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason, the patient's insurance claim is denied, the patient is then considered to be responsible in full for the amount of the bill.

6. Our office will not enter into a "dispute" with an insurance company over any claim. Although we will work with the insurance company to sort out any confusions or questions which might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.

If you understand and agree with all of the above practice policies, please sign your name below and we will accept your insurance assignment.

_______________________________________ ____________________

Signature of Patient or Responsible Party Date