LifeTime Smiles
Cosmetic and Family Dentistry

Health History & Registration

Patient Information

Name _____
First Last Middle Initial Nickname

Address _____
Street

_____
City State Zip Code

Employer _____ Driver's License Number _____

Birth Date _____ Height _____ Weight _____

Phone Home _____ Social Security Number _____

Work _____ Male ☐ Female ☐

Mobile _____

Email Address _____

Emergency Contact _____ Phone Number _____

Insurance Information

Primary Dental Carrier

Subscriber Name _____ Social Security Number _____

Employer _____ Insurance Co. _____

Insurance Co. Phone Number _____ Group Number _____

Subscriber Date of Birth _____ Relation to Patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security Number _____

Employer _____ Insurance Co. _____

Insurance Co. Phone Number _____ Group Number _____

Subscriber Date of Birth _____ Relation to Patient _____

I hereby authorize payment directly to **Lifetime Smiles** of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize **Lifetime Smiles** to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient Under 18

Responsible Party _____ Relation to Patient _____

Address _____

_____ Telephone Number _____

LifeTime Smiles
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It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Dental History

Last COMPLETE Dental Exam, Date: _____

Last FULL MOUTH XRAYS, Date:_____ (16 Small Films or Panoramic)

How do you feel about your teeth? _____

	Yes	No
Are you having PROBLEMS now?	☐	☐
Please Describe _____		
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you HAPPY with your dentures?	☐	☐
If note, would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you HAPPY with the APPEARANCE of your teeth?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Do you or your spouse snore?	☐	☐
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now? If yes, for what?	☐	☐

FAMILY PHYSICIAN _____
PHONE _____
LAST VISIT _____

	Yes	No
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Does food get stuck in your teeth?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Does anyone in your family have gum disease(Periodontal disease)?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐

Name of Previous Dentist? _____

City: _____ State: _____

Medical History

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

_____

	Yes	No
Have you ever taken Fen-Phen ☐ Redux ☐ Coumadin ☐		
Do you need to premedicate with antibiotics for dental treatment?	☐	☐
Are you PREGNANT/NURSING?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

	Yes	No
AIDS/HIV Pos.	☐	☐
AIS	☐	☐
Alcohol Abuse	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina Pectoris	☐	☐
Arthritis (Rheumatism)	☐	☐
Artificial Heart Valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Blood Disease	☐	☐
Blood Transfusion	☐	☐
Cancer	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐

	Yes	No
Congenital Heart Defect	☐	☐
Cortisone treatments	☐	☐
Cough (persistent)	☐	☐
Cough up blood	☐	☐
Diabetes A1C _____	☐	☐
Drug Abuse	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Facial Surgery	☐	☐
Fainting	☐	☐
Food allergies	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems (please describe)	☐	☐
_____		
Hemophilia (Abnormal bleeding)	☐	☐

	Yes	No
Herpes	☐	☐
Hepatitis	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Jaw pain	☐	☐
Joint Replacement	☐	☐
Kidney disease or malfunction	☐	☐
Liver disease	☐	☐
Low Blood Pressure	☐	☐
Material allergies	☐	☐
Mitral valve prolapse	☐	☐
Nervous problems	☐	☐
Pacemaker/heart surgery	☐	☐
Psychiatric care	☐	☐
Rapid weight gain/loss	☐	☐
Radiation treatment	☐	☐
Respiratory disease	☐	☐

	Yes	No
Rheumatic/scarlet fever	☐	☐
Seasonal Allergies	☐	☐
Seizures	☐	☐
Shingles	☐	☐
Shortness of breath	☐	☐
Skin rash	☐	☐
Stroke	☐	☐
Surgical implant	☐	☐
Thyroid disease or malfunction Tonsillitis	☐	☐
Tuberculosis	☐	☐
Ulcer/Colitis	☐	☐
Venereal disease	☐	☐
Multiple Sclerosis	☐	☐

Is there any other Medical or Dental information that you feel we should know about?

_____

_____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Latex (balloons, gloves, etc.)
☐ Nitrous Oxide ☐ Codeine ☐ Penicillin

Are you aware of being allergic to any other medications or substances?
If yes, list: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I , or my minor child, ever have a change in health.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Financial Policy and Dental Insurance

Thank you for choosing our office for your dental care. We are committed to the success of your oral health. We hope you and your family will feel welcome. We would like to acquaint you with our policies regarding dental insurance, financial arrangements and schedule changes.

We don't want finances to be an issue for our patients. We want you to be comfortable with us, and that includes your financial arrangements. We encourage you to enter into a financial arrangement that is comfortable for you.

- We accept cash, checks, Visa, Master Card, Discover and American Express cards.
- For extensive treatments, we offer up to 12 months of NO INTEREST financing and long term plans with low interest through Care Credit and Springstone. We will conveniently qualify you right here in the office today.

Dental insurance

We will be happy to complete and forward all insurance forms regarding your dental treatment to your primary and secondary insurance company. Our professional treatment is rendered to you, not your Insurance Company. Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. At your request, we will provide all pertinent information to your Insurance Company and we will do our best to help you derive the maximum benefits available; however, we are not responsible for determining what those benefits will be.

Please remember that dental insurance is designed to assist patients obtain dental care and rarely covers more than 1/3 to 1/2 of the total cost of the service. There may be a deductible, a coinsurance payment, and a yearly maximum. We will work with your insurance company to help you determine your benefits and copayments. Please keep in mind that all estimate fees that are quoted to you from your insurance company is not a guarantee of payment from them. We consider these fees as estimates only and we are not implying that your portion of co-payment is payment in full.

Your co-pay and deductible are due at the time appointments are scheduled.

Late Payment Policy:

If you have an outstanding bill that is not paid in full within 30 days after a bill has been sent, there will be a **$20 Late Fee.** There will be an **additional $20** late fee for each bill sent out and not paid. If full payment is not received within 90 days, further collection efforts will be necessary.

Collection Accounts:

If your account is sent to a collection agency, you will be responsible for **any** and **all** cost involved with the collections process, which includes **all** court costs and attorney fees.

Returned Checks

If a check is returned, a return check fee of $25.00 will be assessed.

Missed Appointments:

Please understand that we take the time that we have scheduled for your appointment very seriously and we hope for the same consideration. Please consider your calendar carefully when scheduling an appointment. Missed appointments and appointment changes with less than **2 business days** notice will be charged a fee of **$75** per scheduled appointment.

Your signature below indicates that you have read and agree to our Financial Policy and Dental Insurance Agreement. Thank you for being our valued patient.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Print Name

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient's Name: _____ Date of Birth: _____

I understand that, under the Health Insurance Portability Accountability Act of 1996, I have certain rights to privacy. In regards to my protected health information (PHI); I have received, read and understood The Notice of Privacy.

The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship: _____

If Patient is over the age of 18, or Patient would like us to discuss dental treatment, finances, etc. to anyone else such as a parent or spouse, please fill out the following information.

Name the person that we can discuss your care with:

Name: _____

Phone Number: _____

Relationship: _____