Patient Information

Name (First, MI, Last):_____

Circle all that apply: Married Single Minor Male Female

Address: _____ City, State, Zip_____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Cell:_____ Work:_____

Email: _____

Place Of Employment: _____

Please Name the person responsible for this account and your relationship, if other than

yourself: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you to our office? _____

HIPAA Release

I authorize the release of personal information, including diagnoses, records, and examinations rendered to me, as well as insurance claims information.

This information may be released only to your insurance company and other medical professionals. Your personal information will not be used for any other purposes and will remain confidential.

My health records may also be released to:

Spouse_____
Child (ren)_____
Other_____

Sign/Date:_____

**Are you currently or have you in the past been treated for Congenital Heart Defect, Heart Valve Replacement, Bacterial Endocarditis, Joint replacement, or any other medical condition that requires antibiotic pre-medication prior to dental treatment?

Yes No

If yes, please explain: _____

DENTAL HISTORY AND CONSENT FOR TREATMENT

Reason for seeking dental care at this time _____

Date of last dental visit _____ Reason? _____ Date of last X-rays _____

Former dentist _____ City/state _____

How often do you: **Brush** _____ times per _____ **Floss** _____ times per _____

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

☐Aching or sensitive teeth	☐Broken filling	☐Areas of food traps	☐Unfavorable dental experience
☐Sensitive or bleeding gums	☐Loose teeth	☐Difficulty opening wide	☐Growths or lesions in your mouth
☐Broken or missing teeth	☐Bad breath	☐Clicking or popping in jaw	☐Cold sores
☐Grinding or clenching	☐Swollen glands	☐Jaw pain or tiredness	☐Dry mouth
☐Swelling or lumps in mouth	☐Gum infection	☐Orthodontic treatment	☐Other _____

If you could change your smile, what would you change?

☐Remove unsightly fillings	☐Straighten teeth	☐Change shape of teeth	☐Close gaps between teeth
☐Replace missing teeth	☐Whitening	☐Make teeth same color	☐Other _____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of patient or authorized responsible party	Relationship	Date

DENTAL HISTORY AND CONSENT FOR TREATMENT

Eaglesoft update 6/23/20

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Angina ◯ Yes ◯ No
Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No
Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No
Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No
Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No	Asthma ◯ Yes ◯ No
Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No
Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No
Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No
Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No
Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No
Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No
Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No
Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No		

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

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.

Signature of Patient, Parent or Guardian:

X Date:_____

Lyman Family Dentistry
Office Financial Policies & Assignment of Insurance Benefits

PAYMENTS for services are due at time of treatment.

Insurance: As a courtesy to our patients we will provide an estimate of your insurance coverage & benefits. We will also file your insurance claims and accept payment directly from the insurance companies for the covered portion of your treatment.

All co-pays, deductibles, and patient portion of payments are due the day of service.

Any account balances remaining due to declined insurance coverage or limitations by insurance will be billed immediately upon receiving the insurance benefits statement. This balance will also be due within 10 days after receiving statement.

Patient Financing: Payment options include; Cash, Check, Debit, Visa, MasterCard, Discover, American Express, and longer term financing is available through CareCredit for some treatments.

Exams: Treatment cannot be provided without proper evaluation and examination of your condition, therefore examinations are required for all new patients, including emergency patients. This will be in addition to any fees for other services provided such as extractions, fillings, etc.

X-Rays: Appropriate radiographs (x-rays) are required for the Doctor to properly diagnose and evaluate the patient's dental condition. We make all efforts to control costs to our patients, but when needed, x-rays must be taken in order to provide the best quality dental care for our patients.

Appointment Rescheduling: We reserve our appointment times especially for our patients on an individual basis, and we strive to accommodate your schedule. Since we make arrangements to reserve our dental treatment rooms especially for your appointment, we must ask that you give a minimum of 48 hours notice in order to change or reschedule your appointment time. If you cancel or break your appointment without adequate notice, our office reserves the right to charge a broken appointment fee of $30.

Returned Check Fees: Personal checks are accepted for any services, but due to bank fees, our office charges a $30 fee for any bounced or returned checks. After a returned check, we must also ask that you make your payments in the form of cash or credit card.

****By Signing a copy of the Financial Policy Statement, the patient understands all the policies stated above and also agrees to allow assignment of dental insurance benefits and payments be made directly to our office.**

Signature:_____

Please indicate the method of payment for today and future appointments:
___Payment in full at each appointment
We Accept: Cash, Check, Visa, MasterCard, American Express, and Discover
___Payment utilizing Care Credit financing (If eligible)