LEMONS DENTAL
Family & Cosmetic Dentistry

Date: _____

PATIENT INFORMATION

Last Name_____ **First**_____ **MI**_____

Preferred Name_____ **Sex** M F **DOB**_____ **SSN**_____

Marital Status Single Married Divorced Widowed Child

Mailing Address_____

City _____ **State** _____ **Zipcode** _____ **Driver's License #** _____

Emergency Contact _____ **Relationship** _____ **Phone #** _____

Employer_____ **Occupation**_____

Phone Numbers **Home** _____ **Cell**_____ **Work**_____

Best way to confirm your appointment? Email Text Call All None

Whom may we thank for referring you? _____

Insurance Information

Primary	Secondary
Policy Holder Name _____	**Policy Holder Name** _____
Insured DOB _____	**Insured DOB** _____
SSN _____	**SSN** _____
Employer _____	**Employer** _____
Employer Ph# _____	**Employer Ph#** _____
Dental Ins Company_____	**Dental Ins Company** _____
Group Number_____	**Group Number** _____
ID Number _____	**ID Number** _____

Patient Name _____

Signature _____ **Date** _____

MEDICAL HISTORY

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General Health Excellent Good Fair Poor **Currently under the care of a physician?** Yes No

Date of Last Physical_____ **Name of physician**_____ **Phone** _____

Do you smoke or use tobacco products? Yes No If yes, how much? _____

Are you pregnant or think you may be? Yes No If yes, expected delivery date: _____

Are you nursing? Yes No **Are you taking birth control pills?** Yes No **Last X-rays?** _____

Do you or have you used controlled substances? Yes No **Do you bruise easily?** Yes No

Do you take any daily blood thinners? (Aspirin, Plavix, Coumadin) Yes No If yes, please list _____

Do you take anything for the treatment/ prevention of osteoporosis? Yes No If yes, please list _____

Please list any medications you are taking now:

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Are you allergic or had reactions to any of the following?

Local anesthetic like Novocaine….. Yes No Sulfa Drugs…….. Yes No Aspirin…….. Yes No

Penicillin or other antibiotics…….. Yes No Any metal (nickel, etc.)…….. Yes No Latex/Rubber…… Yes No

Barbiturates, sedatives, sleeping pills……. Yes No Other (please list) _____

Have you ever had (circle those that apply):

- Abnormal blood pressure High Lov
- AIDS or HIV
- Allergies
- Anemia
- Arthritis
- Asthma or Hay Fever
- Back Problems
- Blood Transfusion
- Cancer
- Chemical dependency
- Chemotherapy for any cancers
- Cold sores or fever blisters
- Congenital heart lesions
- Diabetes
- Drastic Weight loss
- Eating Disorders
- Enlarged/ Swollen Lymph Nodes
- Epilepsy or Seizures problems
- Excessive urination or thirst
- Fainting spells
- Glaucoma
- Heart Disease
- Heart murmur
- Heart Surgery
- Hepatitis
- Jaundice
- Joint replacement or implant

Kidney trouble
Mental health care
Mitral valve prolapse
Pacemaker
Persistent diarrhea
Prolonged bleeding
Rheumatic fever
STD's
Sinus trouble
Stroke
Thyroid problems
Tuberculosis or lung disease
Ulcers
X-ray treatments for cancer

If you circled any of the above, please explain: _____

Patient Name _____

Signature _____ **Date** _____

Dental Health and Appearance Questionnaire

Reason for visit: _____ Date of last dental visit: _____

What is your primary concern that you would like us to address first?

Has anything ever happened in previous experiences at the dentist that caused you not to return? Yes No

If yes, please explain:

Please rate your smile from 1 to 10 (1= I hate my smile, 10= awesome):

What would you like to change about your smile?

Color Bite Chipped Tooth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

Where would you rate your current dental health?

Where do you want your dental health to be?

Please add anything you feel is important: _____

Please mark any of the following that apply to you

Appearance

- Discolored teeth
- Worn teeth
- Misshaped teeth
- Crooked teeth
- Spaces
- Overbite
- Flat teeth

Pain/Discomfort

- Sensitivity (hot, cold, sweet)
- Pressure
- Broken teeth/fillings
- Worn teeth
- Dry mouth

Function

- Grinding/Clenching
- Headaches
- Jaw Joint (TMJ) pain
- Jaw Joint clicking/popping
- Bad bite
- Speech impediment
- Mouth breathing
- Sore muscles (neck, shoulders)
- Difficulty opening or closing
- Difficulty chewing on either side

Habits

- Thumb sucking
- Nail-biting
- Cheek/Lip biting
- Chewing on ice/foreign objects

Sleep Pattern or Conditions

- Sleep apnea
- Snoring
- Daytime Drowsiness

Periodontal (Gum) Health

- Bleeding, Swollen, Irritated gums
- Bad breath
- Loose tipped, shifting teeth
- Previous perio/gum disease

Social

Tobacco

How much_____ How Long _____

Alcohol Frequency _____

Drugs Frequency _____

Acknowledgment of Receipt of Notice of Privacy Practice

Patient Name & Address

_____
_____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature _____ Date _____

FINANCIAL AGREEMENT

As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the doctor's discretion, for payments in full with cash or check. (Inquire for more details)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said the patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an 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 insurance carrier). Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. Our office will file your claim once services have been rendered. We will do our best to see that you receive your full benefits within the structure of your particular dental plan but any balance that remains on your account, whether your insurance company covered the procedure in question or not, is ultimately your responsibility to pay.

A service charged of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) business days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Lemons Dental's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
Signature of patient, parent or guardian	**Date**	**Relationship**
_____	_____	_____
Signature of guarantor of payment/responsible party	**Date**	**Relationship**

HIPPA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation. Although that revocation will not be effective as to the disclosure of records whos release I have previously authorized, or where other actions have been taken in reliance on an authorization I have signed. I understand that my healthcare and payment for my healthcare will not be effected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature _____ **Date _____**