LANSDOWNE
DENTISTRY
BY DESIGN

WELCOME

Please take a few minutes to complete the following confidential information.
If you have any questions we'll be glad to help you.

PATIENT INFORMATION

Date _____ Social Security # _____ Birth Date _____

Address _____

Last Name _____ First Name _____ Home Phone _____

City _____ State _____ Zip _____

❑ Male ❑ Female Age_____ ❑ Single ❑ Married ❑ Divorce ❑ Widowed

E-Mail Address _____ Cell Phone _____

Where can you be reached during the day? ❑ Home ❑ Work ❑ Cell ❑ E-mail

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Closest relative not living with you _____ Phone _____

Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with *(Name of Insurance Company)* _____

and assign directly to your dentist all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance for myself and/or minor children. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature _____ Date _____

PRIMARY DENTAL INSURANCE

Employee (Subscriber) _____

Insurance Company _____ Group # _____

Employer _____

Business Address _____ Phone _____

Occupation _____

Employee date of birth _____ Social Security # _____ Date employed _____

MEDICAL HISTORY

PATIENT NAME: _____

1. Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No

   If yes, for what? _____

   Physician's Name: _____ Phone: _____

   Address: _____ City: _____ State: _____

2. Have you taken any prescription, herbal, or over the counter medications in the past two years? ❑ Yes ❑ No

   If yes, please list name and dosage: _____

3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ❑ Yes ❑ No

   If yes, please list: _____

4. Have you been a patient in the hospital during the past five years? ❑ Yes ❑ No

Indicate which of the following you have had, or have at present. Check "YES" or "NO" to each item.

	YES	NO		YES	NO		YES	NO
AIDS	❑	❑	Diet (Special/Restricted)	❑	❑	Nervous/Anxious	❑	❑
Allergies or Hives	❑	❑	Emphysema	❑	❑	Neurological Disorders	❑	❑
Arthritis/Rheumatism	❑	❑	Epilepsy or Seizures	❑	❑	Psychiatric/Psychological Care	❑	❑
Artificial Heart Valve	❑	❑	Fainting or Dizzy Spells	❑	❑	Radiation Therapy	❑	❑
Artificial Joints (Hip, Knees)	❑	❑	Glaucoma	❑	❑	Rheumatic Fever	❑	❑
Asthma	❑	❑	Hay Fever	❑	❑	Sickle Cell Disease	❑	❑
Blisters	❑	❑	Heart (Surgery, Disease, Attack)	❑	❑	Sinus Trouble	❑	❑
Blood Transfusion	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Bruise Easily	❑	❑	Heart Pacemaker	❑	❑	Swollen Ankles	❑	❑
Chemotherapy	❑	❑	Hemophilia	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis A or B	❑	❑	Thyroid Problems	❑	❑
Chronic Cough	❑	❑	High Blood Pressure	❑	❑	Tumors	❑	❑
Cold Sores/Fever	❑	❑	HIV Positive	❑	❑	Ulcers	❑	❑
Congenital Heart Disease	❑	❑	Kidney Trouble	❑	❑	Venereal Disease	❑	❑
Contact Lenses	❑	❑	Latex Sensitivity	❑	❑	Yellow Jaundice	❑	❑
Cortisone Medicine	❑	❑	Liver Disease	❑	❑			
Diabetes	❑	❑	Mitral Valve Prolapsed	❑	❑			

5. Do you take, or have you taken, the diet drug Phen-Fen or Redux?* ❑ Yes ❑ No

   *If yes to the above, did you have a medical exam for heart issues? _____

6. Are you taking any medication for the treatment of osteoporosis or bone disease? ❑ Yes ❑ No
7. Do you use more than two pillows to sleep? ❑ Yes ❑ No
8. Have you lost or gained more than 10 pounds in the past year? ❑ Yes ❑ No
9. Do you have or have you had any disease, condition, or problem not listed? ❑ Yes ❑ No

   If yes, please list: _____

10. Women: Pregnant? ❑ Yes #months_____ ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

DENTAL HISTORY

PATIENT NAME: _____

All information is completely confidential.

What is the reason for your visit today?_____

Date of last dental visit: _____ Last dental cleaning: _____ Last full mouth x-rays: _____

Previous Dentist's Name:_____

Address: _____

Telephone: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss?_____

What other dental aids do you use? (Waterpik, tooth pick, ect.) _____

Do you have dental problems now? ❑ Yes ❑ No

If yes please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	❑ Yes	❑ No
Sweets?	❑ Yes	❑ No
Biting or chewing?	❑ Yes	❑ No
Do you frequently get cold sores, blisters or any other lesions?	❑ Yes	❑ No
Do your gums bleed or hurt?	❑ Yes	❑ No
Have your parents experienced gum disease or tooth loss?	❑ Yes	❑ No
Have you noticed any loose teeth?	❑ Yes	❑ No
Have you noticed any change in your bite?	❑ Yes	❑ No
Does food tend to become caught between your teeth?	❑ Yes	❑ No

If so, where? _____

Do you:

Clench or grind your teeth while awake or sleeping?	❑ Yes	❑ No
Bite your lips or cheek regularly?	❑ Yes	❑ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails)?	❑ Yes	❑ No
Mouth breathe while awake or asleep?	❑ Yes	❑ No
Have tired jaw?	❑ Yes	❑ No
Smoke or chew tobacco?	❑ Yes	❑ No

If yes, how many packs a day? _____

Have you ever had:

Orthodontic treatments? (braces)	❑ Yes	❑ No
Oral surgery?	❑ Yes	❑ No
Periodontal treatment? (treatment for gums)	❑ Yes	❑ No
A bite plate or mouth guard?	❑ Yes	❑ No
A serious injury to the mouth or head?	❑ Yes	❑ No

If so, please describe, including cause:

Have you experienced:

Clicking or popping of the jaw?	❑ Yes	❑ No
Pain? (joint, ear, side of face)	❑ Yes	❑ No
Difficulty in opening or closing your mouth?	❑ Yes	❑ No
Difficulty in chewing on either side?	❑ Yes	❑ No
Are you satisfied with your teeth's appearance?	❑ Yes	❑ No

If not, what would you like to change?

Would you like to keep all your teeth all your life?	❑ Yes	❑ No
Do you feel nervous about having dental treatments?	❑ Yes	❑ No

If so, what is your biggest concern?

Have you ever had an upsetting dental experience?	❑ Yes	❑ No

If so, please describe:_____

Is there anything else about having dental treatment that you would like for us to know? ❑ Yes ❑ No

If so, please describe:_____

HIPAA CONSENT FORM FOR LANSDOWNE DENTISTRY BY DESIGN

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change over Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent. The Practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I understand that:

- Protected health information (PHI) may be disclosed or used for treatment, payment of health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking the box below will give your dental office permission to leave as thorough of a message as needed. This will include, but not limited to, appointment day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

_____Patient gives office permission to use any contact written on patient registration form.

Please CIRCLE any that you DO want the office to call. We will be using the numbers/emails you have updated in your account information. All information is subject to availability to verify and validate.

Work Cell Work Phone Work Email Work Fax Mail to Work Personal Cell Home Phone
Home Fax Home Email Mail to Home Emergency Contact Any of these contacts

List names of who can have access to your dental/medical chart information and is allowed to be disclosed or copied. CIRCLE TYPE BELOW:

Financial, Treatment, Health History _____ Phone _____

Financial, Treatment, Health History _____ Phone _____

_____Patient gives office permission to forward any verified contact information and PHI to patient's specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patient's case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name:_____ Date_____

Print Legal Guardian's Name _____ Date_____

Signature of Patient or Legal guardian _____ Date_____

_____Patient refused to sign HIPAA consent. Patient has the right to refuse; USPS or pick up will be used for PHI transfer.

Office Staff Signature _____ Printed Name_____ Date_____

Witness Signature_____ Printed Name_____ Date_____

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ACKNOWLEDGMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Lansdowne Dentistry by Design. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities an duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lansdowne Dentistry by Design reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected heath care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	❑ YES	❑ NO
SPOUSE ONLY	❑ YES	❑ NO
OTHER (Please Specify)	❑ YES	❑ NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Provided Prior To Treatment? ❑ Yes ❑ No

Date Provided: _____

Reason For Denial _____

Needed more time to review Statement of Privacy Practices. _____

Wanted to consult with another person before signing. _____

Unable to sign _____

Reason not given _____

Other (Explain) _____

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FINANCIAL POLICY

Dear Patient:

Thank you for selecting us as your dental care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our front office staff members.

We ask that you read and sign our Financial Policy and complete our Patient Information Form prior to seeing your dentist

Payments for services rendered are due at time of treatment. We accept cash, personal checks, and for convenience, Visa and MasterCard. We shall help you process your insurance claim for your reimbursement as long as we have all of your insurance information. We accept assignment of insurance benefits. However, you will be required to pay the portion of the service that we estimate will not be paid by the insurance company.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to the contract. Our financial relationship is with you, not your insurance company.
2. All charges are your responsibility whether or not your insurance company pays. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductible and co-payments, are due at time of treatment.
4. If the insurance company does not pay your balance within 30 days, we will ask that you contact the carrier to assist with payment in a timely fashion.
5. If the insurance company does not pay in full within 90 days, we will require you to pay the balance due with cash, personal check, MasterCard, or Visa.
6. Balance older than 60 days will be subject to interest charges of 1.5% per month. Returned checks will have an additional fee of $28 added to the amount of the returned check.
7. If it becomes necessary, in our discretion, to turn an overdue account over to our attorney for collection, you will be responsible for costs of collection, to include court costs and attorney's fees actually incurred in the collection of your account.

   Please note that, unless canceled at least 48 hours in advance, you may be charged for missed appointments at the rate of $60.00. Please call the office as soon as possible if you have to reschedule.

PLEASE INITIAL_____

We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing our practice as your dental care provider. We appreciate your confidence and the opportunity to serve you.

BY SIGNING THIS FORM YOU HAVE READ THE ABOVE AND FULLY UNDERSTAND THE TERMS.

Signature _____ Date_____

LANSDOWNE
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ASSIGNMENT AND RELEASE

I the undersigned have insurance with (*Name of Insurance Company)* _____ and assign directly to Lansdowne Dentistry by Design all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

MINOR/CHILD CONSENT

I, being the parent or guardian of (*Name of minor /child)*_____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____ Signature of Insured/Guardian _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date _____ Signature of Insured/Guardian _____

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We ask that you read and sign our Financial Policy and complete our Patient Information Form prior to seeing Lansdowne Dentistry by Design.

Payments for services rendered are due at time of treatment. We accept cash, personal checks, and for convenience, Visa and Master Card. We will help you process your insurance claim for your reimbursement as long as we have all of your insurance information and you bring a complete claim form at your next visit. We accept assignment of insurance benefits. However, you will be required to pay the portion of the service that we estimate will not be paid by the insurance company.

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CONSENT FOR TREATMENT TO A MINOR CHILD

Date:_____

My child, _____, age_____ has permission to have necessary dental treatment performed. This treatment may include, but is not exclusive of:

- Dental radiographs
- Fluoride treatment
- Panoramic – full mouth set of x-rays

Health History changes are _____

Date of Last Physical: _____

Weight: _____lbs.

Health conditions (surgery, illnesses, or injuries since last dental visit):

_____

_____

Medications:

(Include over the counter medications and herbal remedies.)

NAME	DOSAGE	HOW OFTEN	TIME OF DAY TAKEN

Name of Physician(s): _____

Phone(s) #: _____

I do ❑ or do not ❑ have any dental concerns. If you do have concerns, please describe them below:

_____

_____

Parent/Guardian Signature _____