LM FAMILY DENTISTRY

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Email address _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

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

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

Please have your insurance card available during your appointment. You may also email your insurance card to office@lmfamilydentistrytx.com

FINANCIAL AND PAYMENT GUIDELINES

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance.

∟ I understand that in the event I do not cancel my appointment within twenty-four hours of the scheduled appointment a cancellation fee may be charged.

∟ I authorize direct payment of my insurance benefits to Lindsey B Merchant Dentistry PLLC (LM Family Dentistry) for services rendered to myself or dependents.

∟ Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand

that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.

∟ Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.

∟ Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.

∟ LM Family Dentistry or its authorized agent will provide medical information to the insurance company as required for payment of claims for servicesrendered.

Signature of patient (or parent) _____

Date _____

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Patient Photo Release Form

I hereby authorize LM Family Dentistry and / or any of their assignees to take photographs, slides, and / or videos of my (face, jaws, and teeth).

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I do not expect compensation, financial or otherwise, for the use of these photographs.

For a photograph of me, I represent and certify that (a) I am of legal age OR (b) for a photograph of a minor child, I represent and certify that I am the parent or the legal guardian of that child. Further, I represent and certify that I am not under any legal disability and that I have read the foregoing carefully and fully understand the contents and meaning of this release.

To be signed by parent or guardian if under the age of 18.

Print Name

_____

Sign

_____

LM FAMILY DENTISTRY

HIPAA Consent

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

To be signed by parent or guardian if under the age of 18.

Print Name _____ Signature _____

LM FAMILY DENTISTRY

General Consent

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at LM Family Dentistry. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, nitrous oxide and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

To be signed by parent or guardian if under the age of 18.

Print Name

_____

Sign

_____