LAKELAND FAMILY DENTISTRY

Last Name_____ First Name_____ Nickname_____ Date_____

Birthdate_____ Age_____ Sex: __Male __Female Social Security #_____

Home Tel. #_____ Cell #_____ Business Tel. #_____ E-mail _____

Home Address_____ City_____ State _____ Zip_____

Patient's Employer _____Present Position_____ How long held?_____

Business Address_____ City_____ State_____ Zip_____

Spouse's Name_____ Spouse Employed By_____ Spouse's Business Tel. #_____

Nearest Relative Not Living With You_____ Relationship_____ Tel. #_____

Who will pay this account? _____ Do you have dental insurance? __Yes __No

Who may we thank for referring you?_____ Relationship to you?_____

1. Full payment is due at the time services are rendered.

2. For our patients who are covered by a dental insurance plan, we will be glad to file the claim for you. You will need to pay the deductible and 30% of the charges for minor procedures. You will need to pay 50% of the charges for all other procedures.

3. I hereby authorize payment of the dental benefits otherwise payable to me directly to Lakeland Family Dentistry (Drs. Stephen A. Greer, David Henry, Charles F. Ezelle, Paul C. Riley). I give my full consent to Dr. Stephen A. Greer, Dr. David Henry, Dr. Charles F. Ezelle and Dr. Paul C. Riley and staff to render dental care to me and agree that I am ultimately the party responsible for paying any and all fees incurred.

   Your Signature_____

We are delighted to have you in our office and we will strive to do everything possible to keep you comfortable. Thank you for coming today. Philippians 4:-7 in God's Word tells us to "Be anxious for nothing, but in everything by prayer and supplication with thanksgiving, let your requests be made known to God, and the peace of God which surpasses all comprehension, shall guard your hearts and your minds in Christ Jesus."

Please use the space below to make comments if you so desire, then complete the other side of this form.

_____

_____

_____ **PLEASE COMPLETE THE OTHER SIDE OF THIS FORM. THANK YOU!**

Medical and Dental Health History

Do you now have or have you ever had:	No	Yes	If Yes, please describe:
AIDS			
Anemia			Have you had anemia recently?
Arthritis			Arthritis bothers you in which joints?
Diabetes			Do you take medication for diabetes? What?
Stomach Ulcer			Is this a recent problem with stomach ulcers?
Epilepsy			Are you taking medication for epilepsy? Yes____ No____ When was your last seizure?
Hepatitis			When did you have hepatitis? Were you hospitalized?
Rheumatic or Scarlet Fever			
Heart Murmur			Have you ever been told to take antibiotics to protect your heart prior to dental work? Yes_____ No_____
Abnormal Heart Condition			Be specific: Have you ever been told to take antibiotics prior to dental work? Yes____ No____
Artificial or Prosthetic Joints			Which joints? Have you ever been told to take antibiotics prior to dental work? Yes____ No____
Abnormal blood pressure			High or low blood pressure?
Abnormal bleeding problems			Please describe:
Are you allergic to: Latex			
Penicillin			
Dental Anesthetics			
Codeine			
Any other drug allergies?			Which drugs?
Please list any medication you are presently taking including any aspirin:			
Name of your physician: Telephone # of your physician:			
If female, are you pregnant? If yes, what is your due date?			
What is the name of your OB-GYN doctor:			
All patients please answer these questions concerning your dental heath:	**NO**	**YES**	**If yes, please describe:**

Do your gums bleed?			When do your gums bleed?
Do you use dental floss?			How often do you floss?
Do you have a problem with food getting trapped between your teeth?			Which teeth trap food?
Do you use tobacco? Smoke___ Chew___			How much do you smoke?
Do you catch yourself squeezing your teeth together?			When do you squeeze your teeth?
Do you have pain or muscle tenseness around your jaw or ears?			Please specify:
Do you have popping or clicking noises when you chew?			On the left side or right side or both?
Have you ever had your teeth straightened with braces?			Doctor's name that did your braces:
Have you ever had "laughing gas" at the dentist office to help you relax?			Did the "laughing gas" help?
Would you like to try "laughing gas" in this office?			
Do you have frequent mouth ulcers inside the mouth?			What do you do to treat your mouth ulcers?
Do you have frequent fever blisters outside of the mouth?			What do you do to treat your fever blisters?
Do you have any fear of having dentistry done?			If yes, what bothers you? Needles_____ Noise_____ Other_____
How long has it been since you have been to a dentist?			
If you had an unpleasant dental experience in the past, please describe your experience:			
Are you pleased with the way your teeth look?_____ If no, what concerns you about the appearance of your teeth?			

LAKELAND FAMILY DENTISTRY

FINANCIAL AGREEMENT

Our payment options include cash, *check, credit card (Visa, MasterCard, Discover, American Express), and a third party financial plan through **Care Credit.

INSURANCE:
Cost for services is the patient's responsibility regardless of insurance coverage. However, as a courtesy to the patient, insurance will be filed at the time of service. A patient's insurance is a contract between the patient and the insurance company, not between the doctor and the insurance company. Therefore, it is understood that the patient is responsible for the entire balance of their account regardless of what their insurance pays. Our office will "estimate" what the insurance will pay the patient is expected to pay the difference at the time of service. AN ESTIMATE IS NOT A GUARANTEE OF WHAT THE INSURANCE COMPANY WILL PAY.

The patient will be notified by a statement as soon as all insurance payments are received and payment will be due upon receipt of this statement. Service charges will be added at a rate of $5.00 per month after the first statement has been mailed.

Insurance will be resubmitted in 30 day intervals up to 90 days. If the insurance has not responded after 90 days, the patient is expected to pay the balance in full and follow up with the insurance company. Our office will gladly assist in any way possible to accelerate payment from the insurance company.

FOR A PATIENT WHO DOES NOT HAVE INSURANCE:
Payment for services is due AT THE TIME OF SERVICE. The patient may receive an estimate for dental procedures to be performed before they are scheduled. As a result, the patient should be aware of how much they are expected to pay on the day of their appointment. If the patient is unable to pay this amount, appropriate arrangements much be made BEFORE the procedure is performed.

Any patient who has a balance over 90 days old will not be allowed an appointment unless their balance is paid in full.

It is also understood and agreed that if an account is placed with a third party for collection, the patient could also be responsible for a thirty-five percent (35%) Collection Agency fee, reasonable attorney fees and court costs if legal action is taken to enforce collection.

MINORS:
We are not able to become involved in legal matters concerning responsibility of payment of accounts of minors of divorced parents. The parent bringing the minor into the office is responsible for payment, unless the minor is covered on the other parent's insurance. If this is the case, the policy holder must give verbal approval to be listed as the guarantor.

*All returned checks will result in $30 fee and payment will only be accepted in cash after a check has been returned.

**A confidential application must be completed and approved by Care Credit for this option. This is the only long term financing option we are able to offer.

I understand and accept the terms of this financial agreement.

_____ _____

Signature of Responsible Party Date

LAKELAND FAMILY DENTISTRY

PAYMENT AGREEMENT

I understand that payment for services is due at the time of my visit. I will pay for services rendered in one of the following ways:

_____ CASH/CHECK

_____ CREDIT CARD – Visa, MasterCard, Discover, American Express

_____ CARE CREDIT

_____ INSURANCE* - Today I will pay my deductible and the portion of the fee that my insurance does not cover. **I understand that my insurance is a contract between the insurance carrier and myself – not the insurance carrier and Dr. Greer, Dr. Henry, Dr. Ezelle or Dr. Riley - and that I am still responsible for all dental fees.** If my insurance carrier has not responded to the claim after 90 days, I will pay my account in full and follow up with the insurance company myself.

If I fail to pay any balance that I owe upon demand, I understand that I could also be responsible for thirty-five percent (35%) Collection Agency Fee, reasonable attorney fees and court costs if legal action is taken to enforce collection.

I acknowledge that I have read and understand this Payment Agreement and have also received a copy of the Financial Agreement.

_____ _____

Signature Date

*As a courtesy to our patients, your insurance claims will be filed for you from this office.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's (Sign your name) Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

_ For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)