

# Lake View Dental Center

1800 South Pacific

Mineola Texas 75773

903.569.5569

Fax 903.569.1601

## Patient Information

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
Last First Middle Initial (Preferred Name)

Mailing Address: \_\_\_\_\_  
Number & Street or PO Box

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Email address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Guardian/ Spouse or Person Responsible for Account

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Number & Street or PO Box City State Zip

SSN #: \_\_\_\_\_ DOB: \_\_\_\_\_ Driver License #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Dental Insurance

### Primary Insurance

Insurance Co: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Secondary Insurance

Insurance Co: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Medical History** Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Allergies/Reaction:** \_\_\_\_\_      I have no medication allergies.

\_\_\_\_\_  
\_\_\_\_\_

**Medications/Dosage/Condition:** \_\_\_\_\_ I am not taking any medications.

Please include aspirin/blood thinners, fish oil, supplements, or vitamins

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you taken medication for *osteoporosis*? **\*\*They can stay in your system for 10 years or more.\*\***  
\_\_ Actonel \_\_ Araedia \_\_ Boniva \_\_ Fosomax \_\_ Zometa \_\_ Other \_\_\_\_\_

Women: Are you *pregnant* or *nursing* (how many months)? \_\_\_\_\_

Have you had any *surgeries* (when)? \_\_\_\_\_

Has your medical doctor recommended *antibiotics* before dental care? \_\_\_\_\_

Do you use *tobacco* (If so how much/ how long)? \_\_\_\_\_

**Do you have/ or ever had any of the conditions listed below? \*Each item must be marked\***

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: seasonal	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia
<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorders
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Back/Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Growths/Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted/HPV diseases
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure high/low	<input type="checkbox"/>	<input type="checkbox"/>	Headaches (severe)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems/ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy/RadiationTherapy	<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles
<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver dis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol high/low	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	HIV + AIDS/ARC	<input type="checkbox"/>	<input type="checkbox"/>	Other : _____

I have answered all questions to the best of my knowledge. I will not hold Lake View Dental Center responsible for any errors. You have my consent to ask my respective health care provider. I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**History Review:**  
  
ASA I ASA II ASA III ASA IV **Doctor Signature:** \_\_\_\_\_

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## General Consent Form for Dentistry

*Please read the following concerning your dental care and ask your provider any questions you may have. After doing so please sign and date this general consent form. In addition, depending on your treatment, you may need to sign other treatment-specific form(s).*

### Medical History:

I have provided an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, blood or body diseases, gum or skin reactions or any other conditions related to my health.

### Examinations and radiographs (x-rays):

I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan.

### Changes in treatment plan:

I understand that, because of conditions found while working on the teeth, it may be necessary to change or add procedures to the treatment plan that were not discovered during the examination. I give my consent to the dentist or his assistant to consult with me about additional changes in the treatment plan.

### Drugs, medication(s) and sedation:

I understand that antibiotics, analgesics and other medications can cause allergic reactions resulting in redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I consent to the type of anesthesia deemed best by my doctor. I understand potential complications may include pain, swelling, infection, transient discoloration or numbness of the lip, tongue, chin, cheek or teeth. I understand that failure to take medications prescribed to me in the manner instructed may offer risks of continued or aggravated infection, pain or potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

### Hygiene:

I understand that proper home care (regular brushing, flossing and other specific instructions) is essential, and that routine, professional cleanings and exams are necessary to maintain good oral health. I understand that without proper home care, even the best dental restorations cannot be expected to last.

### Dentistry:

I understand that dentistry is not an exact science and therefore that reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist or corporate entity other than the treating dentist is responsible for my dental treatment.

Patient Name (please print): \_\_\_\_\_ Date of birth: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# LAKE VIEW DENTAL CENTER

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## Business Policy

Lake View Dental Center is committed to providing you with the best dental care we possibly can. Additionally, it is important that you, as our patient, fully understand your treatment plan and the fees involved, as you contract for services with your dental care provider. **Our office policy requires that payment of fees be made in full at the time of treatment.** Any other arrangement for payment must be made in advance with the business manager. The following are accepted methods of payment.

- **Cash or check** (requires valid photo identification). There is a service charge of \$35.00 for returned checks.
- **Visa, Mastercard, American Express, Discover** credit cards
- **Care Credit** (for treatment of \$300 or more; 12-months deferred interest if you qualify)
- **Assignment of insurance benefits:**
  1. We cannot always predict the exact amount your insurance will pay, although we will estimate to the best of our ability the portion your insurance will cover. As a service we will file your insurance for you. *It is the decision of your insurance company what they will pay for your treatment. Ultimately, you are responsible for all the charges.*
  2. We cannot accept responsibility for collecting your insurance claim. Therefore, if payment is not received from your insurance carrier within 30 days from the date of service performed, you are responsible for paying the balance owed. Account balances over 90 days are subject to being turned over to a collections agency unless arrangements to settle the account are made.
  3. My signature below indicates my willingness to assign all dental benefits to which I (or my dependents) am entitled, to Lake View Dental Center. I understand that I am responsible for any amount not covered by my insurance.

**Regarding appointments, our policy is that our providers will, to the best of their ability, see you as close to your appointment time as possible.** This time is blocked off for you, in order that you may receive specific attention from our providers. If you do not show for your appointment, we may charge you a fee. Our policy is:

- If you are **twenty minutes late**, we will have to reschedule your appointment.
- If you need to reschedule an appointment, please give us 24 hours prior notice.
- If you miss two scheduled appointments without having given a 24-hour prior notice, we will not schedule future appointments.
- If you have an overdue account, we will not see any member of your immediate family until the account is settled.

My signature below signifies my acceptance of these terms.

Patient Name (please print) \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Staff Initial \_\_\_\_\_

**HIPAA OMNIBUS RULE**

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT**

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI (PROTECTED HEALTH INFORMATION)DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS/PHOTOGRAPHS OR IMAGES BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

**Please list who can have access to your health information:**

(includes step parents, grandparents, any care takers who can have access to this patient’s records)

Name:	Relationship/Date of Birth:
_____	_____
_____	_____
_____	_____
_____	_____

I authorize contact from this office to *confirm my appointments, treatment, billing information, and information about my health or new health information* via:

Any of the Below

Cell  Home  Work  Text  Email

How do you want to be addressed when summoned from the reception area?

First name only  Proper surname  Other: \_\_\_\_\_

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA, provide you this information with your knowledge and consent.

_____	_____
Printed name of Patient	Legal Representative/ Guardian

_____	_____
Signature of Patient / Date	Relationship of Legal Representative/Guardian



Office use only:

As Privacy Officer, I attempted to obtain the patient’s (or representative) signature on this Acknowledgement but did not because:

emergency treatment  could not communicate  patient refused  unable to sign

other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Privacy Officer