Chain of Lakes
Family Dentistry

PLEASE PRINT

PATIENT'S NAME	LAST	FIRST	MI	I WISH TO BE ADDRESSED AS	DOB	M ☐ F ☐
PATIENT'S HOME ADDRESS (CITY, STATE, AND ZIP CODE)					SOC. SECURITY #	
PHONE NUMBER	CELL		HOME		WORK	
EMAIL ADDRESS						
IF PATIENT IS UNDER 18	LEGALLY RESPONSIBLE PARTIES NAME, PHONE #, AND ADDRESS					
PATIENT'S EMPLOYER & OCCUPATION						
SPOUSE'S NAME					MARTIAL: S [] M [] D [] W []	
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY NAME	RELATIONSHIP			CELL NUMBER		

I AUTHORIZE THE USE OF PHOTOGRAPHS, X RAYS, AND/OR TESTIMONIALS FOR EDUCATIONAL PURPOSES/ADVERTISING AT THE DOCTORS DISCRETION. YES/NO	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE
PRIMARY PHYSCIAN/CARDIOLOGIST NAME AND PHONE NUMBER	PREFERRED PHARMACY NAME ADDRESS AND PHONE #

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for dental benefits.
I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist when recommended by the doctor. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services.
I attest to the accuracy of the information on this page.

SIGNATURE: _____ DATE: _____

DENTAL BENEFIT INFORMATION

DENTAL INSURANCE COVERAGE YES ☐ NO ☐	DENTAL INSURANCE COMPANY NAME	ADDRESS AND PHONE #	
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF ☐ SPOUSE ☐ DEPENDENT ☐	SUBSCRIBER'S DOB	SUBSCRIBER'S SSN
GROUP/PROGRAM NAME	EMPLOYER PROVIDING BENEFIT PLAN		

MEDICAL HISTORY

PATIENT NAME _____ **BIRTH DATE** _____

Are you under a physician's care now?	Yes	No	If yes, please explain: _____ Last Visit:_____
Do you need to premedicate prior to dental Tx? (Artificial Joint, infective endocarditis)	Yes	No	If yes why: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs? (also include vitamins and supplements)	Yes	No	If yes, please explain/attach list_____
Do you take/have you taken Blood Thinners?	Yes	No	Please list: _____
Do you take/have you taken Steroids?	Yes	No	Please list: _____
Do you take/have you taken Osteoporosis medications?	Yes	No	Please list: _____
Do you have low Vitamin D?	Yes	No	
Do you take/have you taken, Phen-Fen or Redux?	Yes	No	If yes, please explain: _____
Are you on a special diet?	Yes	No	f yes, please explain: _____
Do you use tobacco?	Yes	No	Please list type and frequency: _____
Do you use controlled substances?	Yes	No	Please list type and frequency: _____

Women: Are you…
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
Other ☐ If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV positive	Y N	Cortisone Medicine	Y N	Hemophilia	Y N	Radiation Treatment	Y N
Alzheimer's	Y N	Diabetes	Y N	Hepatitis A	Y N	Recent Weight Loss	Y N
Anaphylaxis	Y N	Drug Addiction	Y N	Hepatitis B or C	Y N	Renal Dialysis	Y N
Anemia	Y N	Easily Winded	Y N	Herpes	Y N	Rheumatic Fever	Y N
Angina	Y N	Emphysema	Y N	High Blood Pressure	Y N	Rheumatism	Y N
Arthritis/Gout	Y N	Epilepsy/Seizures	Y N	High Cholesterol	Y N	Scarlet Fever	Y N
Artificial Heart Valve	Y N	Excessive Bleeding	Y N	Hives/Rash	Y N	Shingles	Y N
Artificial Joint	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Sickle Cell Disease	Y N
Asthma	Y N	Fainting/Dizziness	Y N	Irregular Heartbeat	Y N	Sinus Trouble	Y N
Blood Disease	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Spina Bifida	Y N
Blood Transfusion	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Intestinal Disease	Y N
Breathing Problem	Y N	Frequent Headache	Y N	Liver Disease	Y N	Stroke	Y N
Bruise Easily	Y N	Genital Herpes	Y N	Low Blood Pressure	Y N	Swelling of Limbs	Y N
Cancer	Y N	Glaucoma	Y N	Lung Disease	Y N	Thyroid Disease	Y N
Chemotherapy	Y N	Hay Fever	Y N	Mitral Valve Prolapse	Y N	Tonsillitis	Y N
Chest Pains	Y N	Heart Attack/Failure	Y N	Osteoporosis	Y N	Tuberculosis	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Pain in Jaw Joints	Y N	Tumors/Growths	Y N
Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N	Ulcers	Y N
Convulsions	Y N	Heart Disease	Y N	Psychiatric Care	Y N	Venereal Disease	Y N
						Yellow Jaundice	Y N

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____
DR'S SIGNATURE: _____ DATE: _____

DENTAL HISTORY

PREVIOUS DENTIST NAME AND PHONE NUMBER: _____
WHEN WAS YOUR LAST DENTAL EXAM: _____
WHAT WAS THE LAST TYPE OF DENTAL TREATMENT THAT YOU HAVE RECEIVED? _____
HOW OFTEN IN THE PAST HAVE YOU RECEIVED CARE FROM A DENTAL HYGENIST? 3MO_ 4MO_ 6MO_ LONGER_
(SCALLING, PROPHY, "CLEANING", ETC.)

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING.

1. Are you happy with the appearance of your teeth? ---------- YES/NO
2. Have you lost any teeth or have any teeth been removed? ----------– YES/NO
   Why? _____
3. Have you had any problems getting numb or bad reactions to anesthetic? ---------- YES/NO
4. Have you had Orthodontic treatment (braces)?---------- YES/NO
5. Do you wear retainers? ---------- YES/NO
6. Are you aware of clenching or grinding your teeth ? ---------- YES/NO
7. Do you wear a protective guard? ---------- YES/NO
8. Have you had Periodontal (gum) treatment? If yes, when? ---------- YES/NO
9. Do you prefer sedation (N2O/Valium for dental treatment? ----------YES/NO
10. Are you currently experiencing any of the following?
    a. Bleeding gums ----------YES/NO
    b. Avoid brushing any part of your mouth ----------YES/NO
    c. Part of your mouth is sensitive to temperature ----------YES/NO
    d. Sore teeth ----------YES/NO
    e. A burning sensation in your mouth ----------YES/NO
    f. Difficulty swallowing ----------YES/NO
    g. An unpleasant taste or odor in your mouth ----------YES/NO
    h. Dry mouth ----------YES/NO
    i. Jaw problems (temporomandibular joint) ----------YES/NO
    j. Stiff neck muscles ----------YES/NO
    k. Awaken with an awareness of your teeth or jaw ----------YES/NO
    l. Jaw clicking or popping ----------YES/NO

IS THERE ANYTHING WE SHOULD KNOW IN ORDER TO MAKE YOUR VISIT WITH US MORE COMFORTABLE?

_____

Patient's Signature:_____ Date:_____

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care so that you may attain optimum oral health.

The following is a statement of our Financial Policy which we require that you read, understand, agree to, and sign prior to any dental treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, Visa, MasterCard, American Express, Discover, and Care Credit. Additional financing options may be made at the discretion of the Office Manager/Financial Coordinator.
Please note: A $35 fee will be applied to returned checks. Account balances over 90 days are subject to finance charges.

Do you have dental Insurance?
Chain of Lakes Family Dentistry does not dictate your level of care based on insurance coverage. As a courtesy to you, we will help you process your Primary Dental PPO Insurance claims. We do accept several PPO insurances for select procedures, however, knowledge of your specific plan is your responsibility. You are also responsible for verifying that your plan is currently active and for notifying the office of any changes in insurance before each visit.
Please understand that we will provide you a treatment estimate only guaranteeing our standard fees for 90 days, if insurance coverage can be factored, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums. Your insurance company and plan benefits ultimately determine the amount paid. We do all that we can to get your estimate as close as possible with the basic information that is provided to us.
All charges you incur are your responsibility, **regardless of your insurance coverage**. We must emphasize that as your dental care provider, our relationship is with you, our Patient, not with your dental insurance company.
Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 45 days, we ask that you contact your insurance company to make sure that payment is expected. If your claim has been denied or not paid within 90 days, you will be responsible for paying the full amount at that time.
We will cooperate fully with the regulation and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
If we must proceed to collection services, you will be responsible for all fees.

Unaccompanied Minor:
Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment.

Missed Appointment(s) and Cancellations:
We do require at least 24 hours notice to cancel or modify your scheduled appointment. We understand that unforeseen circumstances may arise, which may result in cancelling or changing your appointment. A charge of $50 may be assessed for missed, short notice or cancelled appointments. Multiple failed appointments may result in dismissal from the dental practice.

Consent:
I have read, understand, and agree to the above terms and conditions. If applicable, I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient/Legal Guardian Name Printed: _____

Patient/Legal Guardian Name Signed: _____

Date: _____

Thank you in advance for your confidence in our office. We look forward to providing you with exceptional care and courteous service.

Sincerely,
Chain of Lakes Family Dentistry

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have reviewed a copy of this office's Notice of Privacy Practices (on website and posted at front desk).

_____
Please Print Name

_____
Signature

_____
Date

I authorize Chain of Lakes Dental to discuss my personal dental/medical and account history with the following individual(s):

Name	Phone Number	Relationship
1. _____	_____	_____
2. _____	_____	_____

PLEASE NOTE THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS A WRITTEN REQUEST TO RESCIND AUTHORIZATION IS RECEIVED.

_____ _____
Patient 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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevents us from obtaining acknowledgement
- ☐ Other (please specify) _____