Lemon Bay Dental New Patient Paperwork

PERSONAL INFORMATION

Patient's Name: _____ **Preferred:** _____

Social Security# _____ **Birth Day:** _____ **Gender:** ☐ **Male** ☐ **Female**

Cell Phone #: _____ **Other #:** _____

Street Address: _____

City, State, Zip: _____ **Are you a seasonal resident?** ☐ **Yes** ☐ **No**

Email Address: _____

Family Status: ☐ **Single** ☐ **Married** ☐ **Child** ☐ **Widowed** ☐ **Other**

HEALTH INFORMATION

Date of Last Dental Visit: _____ **Reason For Today's Visit:** _____

Please indicate below if you have any of the following medical history.

☐ Allergy: Codeine
☐ Allergy: Erythromycin
☐ Allergy: Latex
☐ Allergy: Penicillin
☐ Allergy: Sulfa
☐ Acid Reflux
☐ AIDS / HIV
☐ Arthritis
☐ Artificial Valves
☐ Artificial Joints (See Front Desk)
☐ Asthma
☐ Back Problems
☐ Blood Thinners (See Front Desk)
☐ Blood/Bleeding Disorders
☐ Cancer
☐ Circulatory Problems
☐ Diabetes
☐ Epilepsy
☐ Fainting / Dizziness
☐ Heart Attack
☐ Heart Stents
☐ Heart Murmur
☐ Hepatitis
☐ Hemophilia
☐ High Cholesterol
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorders
☐ Migraines
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stroke
☐ Swollen Neck Glands
☐ Tobacco Smoker
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Other: _____
☐ Other: _____

OTHER DRUG ALLERGIES: _____

Please list any medications you are currently taking: (You may provide a list if you have one available)

_____ _____ _____

_____ _____ _____

Are you a tobacco smoker? ☐ **YES** ☐ **NO** **How much per day?** _____ **Quit Date:** _____

Have you ever had any complications following dental treatment? ☐ YES ☐ NO
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past year? ☐ YES ☐ NO
If yes, please explain: _____

Do you have a primary care physician? ☐ YES ☐ NO Name of Physician: _____

If you live seasonally in Florida, do you have another dentist? ☐ YES ☐ NO
If yes, please provide dentist's name and city/state: _____

Women: Are you pregnant or nursing at this time? ☐ YES ☐ NO Due Date: _____/_____/_____
Name of OB / GYN: _____ Phone #: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN TODAY'S DATE

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FINANCIAL SECTION

Responsible Party Information: ☐ **Patient** ☐ **Other (Please provide information below)**

Party's Name: _____ **Relationship:** _____

Social Security# _____ **Birth Day:** _____ **Gender:** ☐ **Male** ☐ **Female**

Cell Phone #: _____ **Other #:** _____

Insurance Information

If you have an insurance or discount card, please provide a copy of it and your driver's license with this paperwork.

Primary Insurance: _____

Group #: _____ **Subscriber #:** _____

Employer: _____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Spouse's Name: _____ **Spouse's Date of Birth:** _____

Spouse's SSN: _____

Secondary Insurance: _____

Group #: _____ **Subscriber #:** _____

Employer: _____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Spouse's Name: _____ **Spouse's Date of Birth:** _____

Spouse's SSN: _____

Please ask if you have any questions regarding our fees, financial policy or any information provided below:

- PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
- WE ACCEPT CASH, CHECKS, CARE CREDIT AND ALL MAJOR DEBIT/CREDIT CARDS.
- ALL TREATMENT PLANS FOR INSURED PATIENTS ARE VALID FOR1 BENEFIT TERM.
- ALL TREATMENT PLANS FOR SELF-PAY PATIENTS ARE VALID FOR 90 DAYS.

As a condition of your treatment by our office, financial arrangements must be made in advance. Payment is due at the time of service. The practice depends upon reimbursement from the patient and/or their insurance company. All financial matters will be discussed before treatment is started. Patients who carry dental insurance understand they are financially responsible for their patient portion, which is outlined on a treatment plan after reviewing the patient's benefits. This is only an estimate and does not guarantee payment from the insurance company. A patient may opt to have a predetermination sent to their insurance company but acknowledges a predetermination is not a guarantee of payment either and will accept full financial responsibility for all services rendered despite what insurance may or may not pay. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Lemon Bay Dental. However, if you are paid by the insurance company instead of Lemon Bay Dental, you then become responsible for the total account balance and payment would be expected immediately. Lemon Bay Dental reserves the right to charge 1.5% per month (18% per annum) on any unpaid balances exceeding 90 days, unless previously written financial arrangements have been satisfied.

By signing this form, you are acknowledging you have read these terms and agree to our financial policy outlined in order to become a patient at Lemon Bay Dental and you agree to their content. You agree to let us release your information to your insurance company. You understand that breach of this financial responsibility carries the penalty of compensating the practice for any related attorney and collection fees. You grant permission to Lemon Bay Dental to contact me to discuss matters related to my account.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN TODAY'S DATE

_____ _____

SIGNATURE OF RESPONSIBLE PARTY IF OTHER THAN PATIENT TODAY'S DATE

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PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing, we will not be allowed to process your insurance claims or release any personal information to anyone but you, the patient. This includes even disclosing rather you are or are not a patient of our practice, financial information or even scheduled appointments.
By signing below, you are acknowledging receipt you understand HIPAA and Lemon Bay Dental's policies. You are also giving us permission to disclose information to the individual(s) listed below. You may change this at any time.

Signature of Patient	Print Name of Patient	Today's Date
Legal Representative	Description of Authority	Today's Date

Please List Any Parties Who Can Have Access to your dental information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OFFICE / PATIENT CONTACT

Lemon Bay Dental tries to keep in contact with patients through different forms of communication.
Please indicate all in which you would like to receive.

☐ Cell Phone ☐ Text Message

☐ House Phone ☐ Email

☐ Work Phone ☐ In Person

ADDITIONAL INFORMATION

Please initial next to each that you have read our additional information section and understand Lemon Bay Dental's Policies regarding the following. If you have any questions, please feel free to ask.

_____ Initial

MINORS ACCOMPANIED BY AN ADULT

A parent or legal guardian must list any adults who are authorized to bring their child to their appointment, accept treatment or pay for services on the child's HIPAA form. If they are not listed, a separate authorization form will need to be completed. A parent or legal guardian needs to be present at all times in office during treatment.

_____ Initial

CANCELLATION / NO SHOW POLICY

We reserve the right to charge a $25 fee to patients who miss or cancel an appointment without providing 24 hours-notice.

_____ Initial

X-RAYS

Our office exhibits a strict policy regarding radiographs and your treatment. We are required to have a full series of x-rays on file to perform a complete exam and give a treatment plan. Additionally, once a year, we take a bitewing x-rays and when a patient presents in our office for an emergency visit, we will take a single x-ray to determine the problem.

_____ Initial

BLOOD THINNERS & ARTIFICAL JOINTS

If you are currently on a blood thinner, we will need written permission from your physician to stop the medications for any extractions. If you have had any knee, shoulder or hip replacements, we will need to confirm with your physician or orthopedic surgeon rather you need to premedication before dental appointments.