Welcome to Lifetime Dental: Registration

Patient Information

Name: _____

Email: _____

Home Address: _____

_____

City State zip

Sex: ☐F ☐M Age:_____ Birthdate: ____/____/____

How did you hear about us? _____

Employment Status: ☐Full Time ☐Part Time ☐Other

Marital Status: ☐ Married ☐ Single ☐ Other

Insurance Information

Who is responsible for the account?

Name: _____

Relationship: _____

Home/work#: _____

Employer: _____

Sex: ☐F ☐M Age:____ Birthday:____/____/____

SS#/ID#: _____

Group ID # : _____

Insurance Company: _____

Important Phone Numbers

Cell: ( ) _____ Home: ( ) _____ Work: ( ) _____

IN CASE OF AN EMERGENCY, CONTACT: Name: _____ Relationship: _____

Cell: ( ) _____ Home: ( ) _____ Email: _____

Dental History

Date of your last dental visit?_____ What was done at that visit? _____

☐ Yes ☐ No Do you brush/floss? How often? Brush: _____ Floss: _____
☐ Yes ☐ No Do your gums bleed when brushing or flossing?
☐ Yes ☐ No Are you experiencing dental pain or discomfort?
☐ Yes ☐ No Are any teeth sensitive to: ☐ Heat ☐ Cold ☐ Sweets ☐ Biting ☐ Pressure
☐ Yes ☐ No Do you grind your teeth during the day or when you sleep?
☐ Yes ☐ No Have you ever had orthodontic treatment (braces) before?
☐ Yes ☐ No Does food frequently get stuck between certain teeth?
☐ Yes ☐ No Are you not happy with: ☐ Color ☐ Shape ☐ Spaces ☐ Size ☐ Position
☐ Yes ☐ No Do you have an unpleasant taste or odor in your mouth?
☐ Yes ☐ No Are you fearful of dentistry or have anxiety associated with dental treatment?
☐ Yes ☐ No Have you ever been pre-medicated for dental treatment? If so, what: _____
☐ Yes ☐ No Have you ever had a reaction to anesthetic used with your dental treatment?
☐ Yes ☐ No Do you have children? If so, how many? _____ Last time they went to the dentist? _____
☐ Yes ☐ No Are you happy with your smile?

What are your goals in coming to our practice today?: _____

_____

Welcome to Lifetime Dental: Health History (Confidential)

Although the dentist treats the area in and around your mouth, your mouth is a part of your entire body. Health problems or medications could have an interrelationship with dentistry that you receive. Do you have any of the following health conditions?

☐ Yes ☐ No AIDS/HIV
☐ Yes ☐ No Anemia
☐ Yes ☐ No Allergies
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial joints
☐ Yes ☐ No Asthma
☐ Yes ☐ No Back problems
☐ Yes ☐ No Headaches
☐ Yes ☐ No Blood Disease
☐ Yes ☐ No Bruise Easily
☐ Yes ☐ No Cancer
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Heart issues
☐ Yes ☐ No Developmentally Disabled
☐ Yes ☐ No Drug Addiction
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy/seizures
☐ Yes ☐ No Excessive thirst/urination
☐ Yes ☐ No Fainting or Dizziness
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Abnormal bleeding
☐ Yes ☐ No Hearing Loss
☐ Yes ☐ No Herpes
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Chemotherapy/Radiation
☐ Yes ☐ No Psychiatric Care
☐ Yes ☐ No Special Diet / Ulcers
☐ Yes ☐ No Smoke/Chew Tobacco
☐ Yes ☐ No Special Diet
☐ Yes ☐ No Swollen Feet/Ankles
☐ Yes ☐ No Swollen Neck Glands
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Respiratory Therapy
☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No High / Low Blood Pressure

General Health

☐ Yes ☐ No Are you in good health?
☐ Yes ☐ No Any change in your general health in the past year?
☐ Yes ☐ No Do you have any disease or condition not listed above?
If so, please explain: _____

Women

☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Are you nursing?
☐ Yes ☐ No Taking birth control pills?

Date of your last physical exam: _____ Name of physician _____

Allergies Are you allergic to any of the following:

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Latex
☐ Yes ☐ No Sulfa
☐ Yes ☐ No Codeine
☐ Yes ☐ No Local Anesthetic
☐ Yes ☐ No Other: _____
☐ Yes ☐ No Iodine
☐ Yes ☐ No Penicillin

Medications Please list any medications you are currently taking, including non-prescription drugs and the diagnosis:

_____

Physician's Name/Address: _____ Pharmacy: _____

Your Signature Is Required

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to the patient. I understand it is my responsibility to notify Lifetime Dental of any changes in my health immediately.

Patient Name: _____ Date: _____

Signature: _____ Relationship to patient: _____

Welcome to Lifetime Dental: Practice Policies & Informed Consent

We thank you for selecting Lifetime Dental to serve your dental needs. Our entire staff is a team dedicated to providing the highest quality dental care and service to our patients. So we all can enjoy a smooth working relationship, we ask you to take a few minutes to read over our practice policies. If you have any questions, please do not hesitate to direct your questions to our staff who will be most happy to address your concerns. Thank you, and once again, welcome!

REGULAR VISITS

We will be making a check-up appointment for either three or six months from now, depending on the recommendation of the Doctor once she has examined your teeth and gums. All of our patients participate in this continuing care program. As you may know, studies show that people who do have regular check-ups have much less trouble and save a lot of money in the long run. They also keep their teeth longer! Therefore, we encourage our patients to adhere to the recommended visits.

CANCELLATIONS

If, after setting an appointment, you find that you need to cancel or reschedule your appointment, we ask that you give us at least 48 hours notice. When a patient makes an appointment, that time is reserved for him/her only. If an appointment is canceled on short notice, it is very difficult to fill that slot. We consider an appointment made to be an agreement and commitment between our office and our patients. For that reason, if an appointment is canceled without at least 48 hour notice, a cancellation fee of $65 will be applied to your account for every hour of appointment time missed.

EMERGENCIES

If you have an emergency, please call the office right away. We will do everything possible to get you in at the earliest opportunity. If we are out of the office or if it is after office hours, leave a message and we will get back to you as soon as possible. Or, for immediate assistance, call the emergency number provided on the answering machine.

FINANCIAL ARRANGEMENTS

Having a clear financial policy safeguards the patient and the office from any possible future upset. These are our financial policies:

1. Payment in full is due prior to or at the time of service. The only exception is if you have dental insurance.
2. If you cannot make the payment in full, you can make monthly payments by securing a loan from your banking institution, or by using one of the 3rd party financing options we offer, such as Care Credit, Lending Club, etc.
3. Prepayments by cash or credit card are eligible for up to 10% discount, *if made at the time of consultation.* 3rd party financing is not eligible for this prepayment discount.
4. The methods of payment we accept are: a) Credit card, b) Cash, c) Check, d) Cashier check/Money Order, e) 3rd party financing

INSURANCE

1. As a courtesy to our patients, we do take care of all insurance billing. We ask that you assign your insurance benefits to this office. It is a policy of our office to have the patient pay the co-pay portion at the time of an appointment. Should a problem arise with your insurance payments, if necessary we will request that you contact your insurance company to assist with the resolution. However, you are ultimately responsible for your bill, in the event that your insurance company doesn't pay for services rendered.
2. We reserve the right to store your credit card info, in accordance with the law, and we reserve the right to charge your card if you have an unpaid balance for more than 30 days.
3. If you have no insurance or are unsatisfied with your existing insurance, you can take advantage of our in-house dental savings plan. The benefits of this plan are covered in our membership brochure.
4. There will be no form of insurance fraud at Lifetime Dental. This would include any misrepresentation of the treatment when billing your insurance or billing your insurance without also collecting the required co-pay from you.

COMMUNICATIONS & SOCIAL MEDIA

1. By becoming a patient at Lifetime Dental, you will receive hard copy and electronic communications, including but not limited to mail, email, text messages and calls, related to your dentistry or for marketing purposes.
2. Additionally, Lifetime Dental may take pictures of you or your mouth and post these on the internet or on print media.

TREATMENT

1. During treatment, you may undergo procedures in all phases of dentistry. No guarantees can be made on treatment outcomes, restoration longevity, or prognoses. Any branch of medicine, including dentistry, involves unanticipated results.
2. Patients are welcome to ask any questions about their treatment and should request information if they are confused. You are responsible for clarifying any aspects of your treatment that you are unsure about.

Your Signature Is Required. *I understand and agree to Lifetime Dental's practice policies described above.*

Patient Name: _____ Date: _____

Signature: _____ Relationship to patient: _____