LIFETIME
FAMILY DENTAL

PATIENT REGISTRATION FORM

Last Name	First Name	Middle Initial
Street Address	City/State/Zip Code	Social Security #
Phone Number/Other	Date of Birth	Male or Female
Cell Phone	Email	Marital Status S / M / D / W
Emergency Contact/Phone #	Pharmacy Name & Phone #	

Employer Information:

Name	Work Number	Occupation
Address	City/State/Zip Code	

Referred By: (From whom did you hear about the Doctor? Self referred or from another Doctor?)

Referred By:	Address	Phone #
Primary Care Physician:	Address	Phone#

Insurance Information:

Name of First Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number		Local/Group Number	
Name of Secondary Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number		Local/Group Number	

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security	Address	Zip Code
Home Number	Employer's Name	Work Number

I request that payment under the dental insurance program be made directly to the provider of service on any unpaid bill for services provided. I hereby Authorize Lifetime Family Dental designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of my dental needs.

I have been given a copy of the HIPPA Policy here at the office.

Signature of Patient or Authorized Representative:	**Date:**

Patient Smile Interview Form/Script

With your permission, I'd like to ask you a few questions about your smile. Would that be alright?

What brought you in today? Are you experiencing any pain or have any specific concerns?

_____

_____

If you could change just one thing about your front teeth, those we see when you smile:

What would that be?

_____

_____

How do you feel about the color of your front teeth,
are they white enough? ❑ No ❑ Yes

Do you like the way they are shaped? ❑ No ❑ Yes

Are your front teeth as straight as you'd like them to be? ❑ No ❑ Yes

Are you satisfied with their overall appearance? ❑ No ❑ Yes

Is there anything you'd like to change about them? ❑ No ❑ Yes

Now let's talk about your back teeth, the ones you chew on:

If there was anything you could change about these,
what would it be?_____

Do you have any sensitivity to hot or cold or when you chew? ❑ No ❑ Yes

Do you have any difficulty chewing? ❑ No ❑ Yes

Are you missing any teeth? ❑ No ❑ Yes

Does food get trapped and annoy you? ❑ No ❑ Yes

Is there anything in the back that you'd like us to look at? ❑ No ❑ Yes

_____

_____

Your gums aren't something most people think about, but let me ask you this:

Do your gums ever bleed? ❑ No ❑ Yes

Do you ever experience any sensitivity? ❑ No ❑ Yes

How is your breath?_____

Do you have any recession? ❑ No ❑ Yes

_____

_____

Do you have removable pieces in your mouth? ❑ No ❑ Yes

Are they comfortable? ❑ No ❑ Yes

_____

_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
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? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 _____

Cancellation Policy

All insured and non-insured patients will be charged a $100.00 "no-show" fee and dismissal from the practice may result after subsequent no-shows.

Our goal is to provide the best care we can to all of our patients. The purpose of the policy is to improve scheduling opportunities and encourage patients to cancel their scheduled appointments in a reasonable amount of time of 48 hours prior to their appointment. This would allow for better use of patient, staff and physician time.

Please understand we have patients that are waiting to be seen and if you do not give a reasonable notice of 48 hours we are unable to offer your allotted time with the doctor to another patient in need.

Thank you.

I acknowledge that I have read and agree to the above Terms and Conditions.

Signature_____Date_____

For Dental Insurance Purposes Only

CREDIT CARD ON FILE POLICY

At Lifetime Family Dental, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Lifetime Dental to charge the portion of my bill that is my financial responsibility to the following credit or debit card: ☐Amex ☐Visa ☐Mastercard ☐Discover Credit Card Number

_____ Expiration Date _____ / _____ / _____

CVC code (3 digit security)_____

Cardholder Name _____ Signature

_____ Billing Address

_____ City _____

State_____ Zip _____

I (we), the undersigned, authorize and request Lifetime Dental to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me . This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

*If you do not feel comfortable in providing your financial information, we will gladly collect payment IN FULL for today's services and bill your insurance appropriately. You should receive payment from your insurance within 2-4 weeks.

Patient Name (Print): _____

Patient Signature: _____

LifeTime Family Dental

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relate to your past , present or future physical or mental health condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes,

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example, we will disclose information to a specialist to whom you have been referred to ensure that provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provide for you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call your name in the waiting room when we are ready to begin your treatment.

We will share your protected health information with business associates that perform specific functions of our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others involved in your Health Care: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment of your health care, but only if you agree. If we determine it is in your best interest based on our professional judgment or experience with common practices, we may allow another person to pick filled prescriptions, medical supplies, xrays or other forms of health information.

We may use of disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

Emergencies: In event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosure of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.