CORDELL LAKE, D.D.S.
GENERAL AND COSMETIC DENTISTRY

12 E. Harrison St. Farmington, MO 63640
www.CordellLakeDDS.com
(573)756-4344

First Name (Legal) | Last Name | Date of Birth

Address | City | State, Zip Code

Mobile # | Home # | Work # and Ext.

Email Address | Preferred # (Cell, Home, or Work?)

How would you like to confirm appointments for this patient? *(Please circle an option below)*

Text Message to Cell *Email* *Text & Email* *Phone Call to Preferred #*

If another person should receive the appointment confirmations for this patient, please list them below with the preferred method of contact

INSURANCE

Has your insurance changed since your last visit? If yes, please give as much detail as possible below:

MEDICATIONS

☐ Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? *If yes, please list their name:* _____

☐ Have you ever taken FosaMax, Boniva, Actonel or any other medications containing bisphosphonates?

☐ Are you taking any prescription or over-the-counter medicines? *If so, please list all medications:*

ALLERGIES *(Please check any applicable)*

- ☐ Acetaminophen/Tylenol®
- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Ibuprofen/Motrin®/Advil®
- ☐ Keflex
- ☐ Latex
- ☐ Local anesthetic
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other

CONDITIONS *(Please check any applicable)*

- ☐ Abnormal/excessive bleeding
- ☐ AIDS or HIV infection
- ☐ Alzheimer's/dementia
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Blood disease
- ☐ Blood transfusion
- ☐ Cancer/chemotherapy/radiation treatment
- ☐ Cardiovascular disease
- ☐ Chronic pain
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells or seizures
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart rhythm disorder
- ☐ Hemophilia
- ☐ Hepatitis, jaundice or liver disease
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Mitral valve prolapse
- ☐ Neurological disorders
- ☐ Osteoporosis/Paget's disease
- ☐ Other congenital heart defects
- ☐ Pacemaker
- ☐ Persistent swollen glands in neck
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Rheumatoid arthritis
- ☐ Severe headaches/migraines
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Systemic lupus erythematosus
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers

☐ Do you use tobacco (smoking, snuff, chew, bidis)?

☐ Has there been any change to your general health within the last year? *If yes, please explain:*

☐ Have you had a serious illness/operation/hospitalizion in the past 5 years? *If yes, please explain.*

☐ Are you pregnant? *If yes, list number of weeks below:* ☐ Are you nursing?

DENTAL RELATED CONDITIONS *(Please check any applicable)*

- ☐ Bleeding Gums
- ☐ Sensitivity of Teeth
- ☐ Teeth Grinding
- ☐ Clicking/Popping/Discomfort of Jaw
- ☐ Currently in Dental Pain
- ☐ Problems with Previous Dental Treatments
- ☐ Previous Serious Head/Neck/Mouth Injury
- ☐ Previous Periodontal (gum) Treatments
- ☐ Wear Full Dentures
- ☐ Wear Partial Dentures

Dr. Cordell Lake, DDS

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

* our obligations under the law with respect to your personal health information.

* how we may use and disclose the health information that we keep about you.

* your rights relating to your personal health information.

* our rights to change our Notice of Privacy Practices.

* how to file a complaint if you believe your privacy rights have been violated.

* the conditions that apply to uses and disclosures not described in this Notice.

* the person to contact for further information about our privacy practices.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient Signature Date

_____

Signature of Parent or Patient's Representative (if applicable) Date

_____

Description of Legal Authority to Act on Behalf of Patient

NOTICE TO ALL PATIENTS

Please be aware that we do require 24 hours notice if you need to cancel or reschedule an appointment. By failing to do so, we reserve the right to post a $35.00 charge to your account per appointment.
We also reserve the right to terminate our relationship with patients for failed appointments at our discretion.

Our office files claims with your insurance company as a courtesy to you. It is your responsibility to be aware of any limitations, frequencies, and exclusions that may be in effect on your policy. Generally, we may require a panoramic x-ray to diagnose and treat you. Please advise us if you have had this done within the past 3 years as it could affect your coverage.

In most cases, we can give you a ***general estimate*** of what your portion will be, but if you need a more specific estimate, we encourage you to let us file a pre-determination with your insurance company. This does not obligate you, but rather gives you a more specific estimate of what your cost will be.

I, _____, have read these policies and understand that I will be responsible for any charges not covered by my insurance company.

_____Date_____
Patient Signature