



First Name (Legal)	Last Name	Date of Birth
_____	_____	_____
SSN	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 list 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)*

- | | | | |
|---|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Acetaminophen/Tylenol® | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Ibuprofen/Motrin®/Advil® | <input type="checkbox"/> Keflex | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Metals | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Tetracycline | | | |
| <input type="checkbox"/> Other | | | |

CONDITIONS *(Please check any applicable)*

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

- 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/hospitalization 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)*

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Sensitivity of Teeth | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Clicking/Popping/Discomfort of Jaw |
| <input type="checkbox"/> Currently in Dental Pain | <input type="checkbox"/> Problems with Previous Dental Treatments | <input type="checkbox"/> Previous Serious Head/Neck/Mouth Injury | <input type="checkbox"/> Previous Periodontal (gum) Treatments |
| <input type="checkbox"/> Wear Full Dentures | <input type="checkbox"/> 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

DENTAL INSURANCE

Our office files dental claims with your insurance company as a courtesy to you. We try our best to be aware of common plans and limitations, but, ultimately, it is your responsibility to be aware of any limitations, frequencies and exclusions that may be in effect on your policy.

- For new hygiene patients, we require a comprehensive exam and a full mouth x-ray.
- For patients seeking treatment of a current issue, we generally require a limited exam and an x-ray to diagnose and treat you.

Please advise us if you have had x-rays or examinations performed within the last five years as it could affect your insurance coverage. You will be responsible for what is not covered by your insurance plan. If you have recent x-rays from another provider, you may have them forwarded to us to see if they can be used in lieu of taking new x-rays.

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. It does not obligate you, but rather gives you a more specific estimate of what your cost may be.

FAILED APPOINTMENTS

Please be aware that **we require 24 hours' notice if you need to cancel or reschedule** your appointment. We reserve the right to post a \$35 charge to your account per failed appointment. We also reserve the right to terminate our relationship with patients for failed appointments

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

Patient Signature

Date