Lake Dental Clinic

1497 N. BUSINESS ROUTE 5
P.O. BOX 820
CAMDENTON, MO 65020
(573) 346-7278
www.lakedentalclinic.com

Notice of Privacy Practices Acknowledgment:

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name_____Relationship to Patient_____

Signature_____Date_____

LIST BELOW ANY PERSON WHO CAN RECEIVE HIPAA INFORMATION ON THIS PATIENT

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

OFFICE USE ONLY: I attempted to obtain the patient's signature for this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

Lake Dental Clinic

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ◯ Yes ◯ No If yes

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 Problems ◯ 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 ◯ Yes ◯ No If yes

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:

X_____ Date:_____

LAKE DENTAL CLINIC

Patient Information

Patient Name: First_____MI_____Last_____Nickname_____

Mailing Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone _____Work Phone_____

Male ____ Female ____ Minor ____Single ____Married ____Divorced ____ Separated ____Widow/Widower_____

Date of Birth_____ SS# _____Driver's License#_____

Email Address: _____

Preferred method of contact: _____ Home Phone _____Cell Phone _____Work Phone _____ Email

Responsible Party

Name of person responsible for this account if patient is a minor:

First Name_____ MI_____ Last Name _____Relationship to Patient_____

Mailing Address _____City_____State_____Zip_____

Home Phone _____Cell Phone_____ Work Phone_____

Date of Birth_____ SS# _____Driver's License#_____

Dental Insurance Information

Please provide a copy of your dental insurance card

Primary Dental Plan Name_____Phone_____

Address _____City_____State_____ Zip _____

Name of Insured_____ Relationship to Patient _____Employer _____

Date of Birth _____ID #/SS# _____Group #_____

Secondary Dental Plan Name _____Phone_____

Address_____City_____State_____Zip _____

Name of Insured _____Relationship to Patient_____ Employer_____

Date of Birth_____ID/SS#_____Group_____

PLEASE HAVE ALL CURRENT X-RAYS FROM YOUR PREVIOUS DENTIST EMAILED TO US at frontdesk@lakedentalclinic.com BEFORE YOUR APPOINTMENT.

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Financial Policy, Assignment of Benefits, and General Dental Consent Form

I acknowledge that I have read, understand, and agree to the financial policies of Lake Dental Clinic.

The patient (or patient's guardian if a minor) is financially responsible for the payment of all treatment and care provided by Lake Dental Clinic. Payment is due in full at the time of service including deductibles, co-insurance and/ or treatment not covered by the patient's insurance.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

The patient consents to a returned check fee of $30.00 if the patient's check is declined.

The patient agrees to pay a collection fee of 30% in the event Lake Dental Clinic retains a collection agency. In the event Lake Dental Clinic retains an attorney to collect any amount of a patient's unpaid bill, whether or not a lawsuit is ever filed, Patient agrees to pay legal expenses, including without limitation, court costs and reasonable attorney's fees.

Lake Dental Clinic will file your insurance as a courtesy, if we are out of network with your insurance company. Our proposed treatment plans are estimates only. The patient is financially responsible for any portion of a bill of which your insurance company denies coverage or fails to pay the full amount after accounting for adjustments, denial and other potential considerations.

The patient authorizes Lake Dental Clinic to furnish to dental/health insurance carriers, any or all patient information including but not limited to any and all medical records, notes, test results and radiographs related to treatment (including itemization of any charges and payments on the patient's account) deemed necessary to process any claim.

I authorize Lake Dental Clinic to perform treatment including necessary or advisable examination, radiographs, hygiene, diagnostic aids or local anesthesia.

In general terms, dental treatment may include but is not limited to one or a number of the following:

Administration of local anesthesia, cleaning, application of topical fluoride, scaling and root planning with local anesthesia, application of sealants, restorations, dental prosthesis (crown, bridge, partials, etc.), endodontic therapy.

I understand that during treatment, it may be necessary to change and or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any changes and additions as necessary.

Risk of General Dental Procedures, included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms. TMJ discomfort, loss of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for 24 hours or until recovered from their effects.

Payment is due in full at the time of service including deductibles, co-insurance and/ or treatment not covered by the patient's insurance.

By signing below, I consent to the financial policy and general consent for treatment.

Patient/Guardian Signature:_____

Patient Name Printed:_____

Date:_____