Patient Information

Welcome!

Date: ____________

Patient Name:

First Last Middle Initial

Preferred Name: _________________________ Salutation: _____

Address:

Street (Apt#)

City State Zip

Telephone: (____) __________________ (____)_________________ (____)_________________
Home# Work# Cell#

*****Please circle preferred phone #***
Can we text you appointment reminders Yes / No (circle one)

Sex: Male ____ Female ____

Marital Status: Married ____ Single ____ Divorced _____ Separated ____ Widowed ____

Birthdate: ____/____/______ Age _____ Social Security #: _________________________

Email: ____
Can we email you appointment reminders? Yes / No (circle one)

Employer: _____________________________________ Occupation: ___________________

Person responsible for account (if other than patient)

Legal Name: _____________________________________ Relationship to Patient: _________

Address: ____

Telephone: (____)__________________ (____)_________________ (____)_________________
Home# Work# Cell#

Birthdate: ____/____/______ Social Security #: _________________

Employer: _____________________________________ Occupation: ___________________

Employer Address: ____

(OVER)

Insurance Information

PRIMARY DENTAL INSURANCE INFORMATION:	SECONDARY DENTAL INSURANCE INFORMATION:
Subscriber Name:	Subscriber Name:
Relationship to patient:	Relationship to patient:
Subscriber Social Security:	Subscriber Social Security:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Employer	Subscriber Employer
DENTAL INSURANCE COMPANY:	DENTAL INSURANCE COMPANY:
Effective Date:	Effective Date:
Address of Dental Insurance Company:	Address of Dental Insurance Company:
Phone Number of Dental Insurance:	Phone Number of Dental Insurance:
Member ID #:	Member ID #:
Group #:	Group #:

Miscellaneous Information

Emergency Contact:_____________________________________ Phone #: ________________
Relationship to patient _______________________________

Have any of your family members been to our office: Yes / No (circle one)
If yes, who?____
How did you hear about us? (If internet, where? Google/Facebook/Yelp)? ________________
OR Whom May We thank for the referral? ______________________

Authorization
I hereby authorize payment directly to Lang Dental Group of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Lang Dental Group to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals

Signature of Patient, Parent, or Guardian **Date**

(OVER)

Name: ____ DOB: ____ / ____ / _________

Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. The following questions will insure that we provide you with accurate care during your visit.

○ **Are you under a physician's care now?**	Yes	No	If yes, explain:_________________________
○ **Have you ever been hospitalized or had a major operation?**	Yes	No	If yes, explain:_________________________
○ **Have you ever had a serious head or neck injury?**	Yes	No	If yes, explain:_________________________
○ **Are you on a special diet?**	Yes	No	If yes, explain:_________________________
○ **Do you use smoke or use snuff?**	Yes	No	If yes, explain:_________________________
○ **Do you use controlled substances?**	Yes	No	If yes, explain:_________________________
○ **Have you ever taken Fosamax/Boniva/Actonel/Bisphosphonates**	Yes	No	If yes, explain:_________________________
○ **Do you consider yourself a nervous patient?**	Yes	No	If yes, explain:_________________________
○ **Have you ever used N2O or a sedative during Treatment?**	Yes	No	If yes, explain:_________________________
○ **Are you taking any medications, supplements, or drugs?**	Yes	No	If yes, list:_________________________

(Additional space on back if needed)

Allergies:

____ Aspirin
____ Ibuprofen
____ Iodine
____ Acrylic
____ Metals
____ Latex
____ Milk

____ Codeine
____ Sedatives
____ Sulfa Drugs
____ Penicillin
____ Other antibiotics
____ Local Anesthetics
____ Other:

W***omen are you:***

____ Pregnant/Trying to Conceive?
____ Taking Contraceptives?
____ Nursing?
____ Taking Estrogen Therapy?

Do you have any of the following: (CIRCLE)

AIDS/HIV	**Chest Pains**	**Frequent Diarrhea**
Alzheimer's/Dementia	**Cold Sores**	**Frequent Headaches**
Anaphylaxis	**Congenital Heart Disorders**	**Glaucoma**
Anemia	**Convulsions**	**Heart Attack/Failure**
Angina	**Cortisone Medications**	**Heart Murmur**
Arthritis/Gout	**Diabetes: Type I or Type II**	**Heart Pacemaker**
Artificial Heart Valve	**Drug Addiction**	**Heart Trouble/Disease**
Artificial Joint	**Easily Winded**	**Hemophilia**
Asthma/Breathing Trouble	**Emphysema**	**Hepatitis A, B, or C**

(OVER)

Bleeding Issues	Epilepsy/Seizures	Herpes
Bruise Easily	Excessive Thirst	High Blood Pressure
Cancer	Fainting Spells/Dizziness	High Cholesterol
Chemotherapy	Frequent Cough	Hives/Rash
Hypoglycemia	Parathyroid Disease	Sickle Cell Disease
Irregular Heartbeat	Psychiatric Care	Sinus Trouble
Kidney Problems	Radiation Treatment	Spina Bifida
Leukemia	Recent Weight Loss	Stomach/Acid Issues
Liver Disease	Renal Dialysis	Stroke
Low Blood Pressure	Rheumatic Fever	Thyroid Disease
Lung Disease	Rheumatism	Tonsillitis
Mitral Valve Prolapse	Seasonal Allergies	Tuberculosis
Osteoporosis	Scarlet Fever	Tumors or Growths
Pain in Jaw Joints	Shingles	Ulcers

If you have marked any of the illnesses above please explain: ___________________________

____

____

Any other serious illness not listed:

____

Dental Health Questionnaire:

What is the main reason you made an appointment? _________________________________

____

Do you struggle with dental anxiety/fear? If yes, explain:

____

Do you like your smile? __________________

If you could change something about your smile, what would it be?

____

Do you have dry mouth or dry eyes? If yes, when do you notice it? ______________________

Do you wear a partial or denture? If so, how old is it and how does it fit?

____

Do you snore? _____________ Have you been diagnosed with Sleep Apnea? _______________

Do you wear a CPAP or other sleep apnea appliance? ________________________________

Authorization

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/Guardian (if under age 18) **Date**

Additional Space for Medication List/comments if needed:

(OVER)

Health Information Consent Form

Patient Name: ______________________________________DOB_____/______/______

Consent: By signing this form, you do consent to our use and disclose of your personal health information to carry out treatment, payment activities, and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office privacy policy and information sharing policy.

Right to revoke: You have the right to revoke this consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this consent.

Changes to Privacy Practices: We reserve the right to change our privacy practices described in our Patients Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patients Rights Privacy Policy and Information Practice Statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to: health history information, address, telephone number, active insurance policy, or change in employer.

In addition to the above, please list who we may discuss your healthcare information with: (Please print name and relationship, more room on back if needed):

______________________________________ ____________________________

Name Relationship to patient

______________________________________ ____________________________

Name Relationship to patient

Authorization

I have read and understand the above information. I understand that by signing this form I am giving my consent for Lang Dental Group to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

X

Signature of Patient, Parent, or Guardian ***Date***

(OVER)

Our Financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their dental care.

1) Full payment is expected at the time of service unless other arrangements have been made.
2) A service charge of $15 per month will be added on any unpaid balance after 30 days.
3) If an appointment is broken or cancelled within 24 hours of the appointment time, a charge will be applied to your account. Fee varies based on appointment time.
4) Returned checks are subject to a $25 service charge.
5) It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, you will be responsible for all collection agency fees and/or attorney fees.

Please sign below to indicate that you have read and fully understand said policy.

____

Printed Name (if patient under the age of 18 – guardian's printed name)

____

Signature