Patient Information – Minor (18 and under)

Welcome!

LANG DENTAL GROUP

Date: _____

Minor's Name:

_____

First Last Middle Initial

Preferred Name: _____

Sex: Male ____ Female ____

Birthdate: ____/____/_____ Age _____

School: _____ Grade: _____

Person responsible for account

Legal Name: _____ Relationship to Patient: _____

Address: _____

Telephone: (____)_____ (____)_____ (____)_____
Home# Work# Cell#

Can we text you appointment reminders Yes / No (circle one)

Birthdate: ___/___/_____ Social Security #: _____

Email: _____

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

Employer: _____ Occupation: _____

Employer Address: _____

If the responsible party above is NOT the person we should contact for appointment reminders, please provide contact person's info here:

Name & Relationship _____

Address & Phone Number _____

(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 Parent/Guardian **Date**

(OVER)

Child Medical History (13 and under)

LANG DENTAL GROUP

Name: _____ DOB ____ / _____ / _____

Health problems that your child has, or medications he/she may be taking, could have an important interrelationship with the dentistry he/she will receive. The following questions will insure that we provide him/her with accurate care during his/her visit.

Child's primary care doctor	Yes	No	If yes, doctor's name :_____
Has your child ever been hospitalized or had a major operation?	Yes	No	If yes, Please explain:_____
Has your child ever had a serious head or neck injury?	Yes	No	If yes, Please explain:_____
Is she/he on a special diet?	Yes	No	If yes, Please explain:_____
Do you consider your child a nervous patient?	Yes	No	If yes, Please explain:_____
Has your child ever had N2O or a sedative during treatment?	Yes	No	If yes, Please explain:_____
Is your child taking any medications, supplements, or drugs?	Yes	No	If yes, Please list:_____

Allergy to any of the following:

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Acrylic
- ☐ Penicillin/ antibiotics
- ☐ Milk
- ☐ Other _____
- ☐ Codeine
- ☐ Sedatives
- ☐ Sulfa drugs
- ☐ Metal
- ☐ Local Anesthetics
- ☐ Latex

Does your child have any of the following?

AIDS/HIV	**Low Blood Pressure**	**Frequent Headaches**
Anaphylaxis	**Lung Disease**	**Heart Murmur**
Anemia	**Mitral Valve Prolapse**	**Heart Pacemaker**
Anxiety	**Pain in Jaw Joints**	**Heart Trouble/Disease**
Artificial Heart Valve	**Cold Sores**	**Hemophilia**
Artificial Joint	**Congenital Heart Disorders**	**Hepatitis A, B, or C**
Asthma/Breathing Trouble	**Convulsions**	**High Blood Pressure**
Bleeding Issues	**Diabetes: Type I or Type II**	**High Cholesterol**
Bruise Easily	**Epilepsy/Seizures**	**Hives/Rash**
Cancer	**Fainting Spells/Dizziness**	**Sickle Cell Disease**
Chemotherapy	**Psychiatric Care**	**Sinus Trouble**
Hypoglycemia	**Radiation Treatment**	**Spina Bifida**
Irregular Heartbeat	**Rheumatic Fever**	**Stomach/Acid Issues**
Kidney Problems	**Seasonal Allergies**	**Thyroid Disease**
Leukemia	**Scarlet Fever**	**Tonsillitis**
Liver Disease	**Frequent Diarrhea**	**Tuberculosis**

If you have marked any of the illnesses above please explain/illness not listed: _____

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 Parent/Guardian **Date**

(OVER)

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 Parent/Guardian ***Date***

(OVER)

LANG
DENTAL GROUP

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