Welcome!

ANDERSON LAKE DENTAL REGISTRATION FORM

Section 1: Patient Information Date_____

Name: _____ I Prefer to be called: _____
Address: _____City:_____State:_____Zip_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Email Address: _____
Date of Birth: _____ Social Security Number: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name: _____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____) _____
Employer_____ Work Phone (____) _____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ INS Co. Phone: _____

---------- DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ INS Co. Phone: _____

Anderson Lake
DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____E-Mail_____

Social Security #_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent,

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Terry, 952-942-0823, Fax: 952-224-2986

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____, Date_____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

ANDERSON LAKE DENTAL HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:_____ Date_____

If you are completing this form for another person, what is your relationship to that person?
(Name)_____ (Relationship)_____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)	Y	N	DK
Active Tuberculosis	Y	N	DK
Persistent cough greater than a 3 week duration	Y	N	DK
Cough that produces blood	Y	N	DK
Been exposed to anyone with tuberculosis	Y	N	DK

DENTAL INFORMATION

Do your gums bleed when you brush or floss	Y	N	DK	Do you have earaches or neck pains	Y	N	DK
Are your teeth sensitive to cold, hot ,pressure	Y	N	DK	Do you have any discomfort in the jaw	Y	N	DK
Does food or floss catch between your teeth	Y	N	DK	Do you brux or grind your teeth	Y	N	DK
Is your mouth dry	Y	N	DK	Do you have sores or ulcers in your mouth	Y	N	DK
Have you had any periodontal (gum) treatments	Y	N	DK	Do you wear dentures or partials	Y	N	DK
Have you ever had orthodontic (braces) treatment	Y	N	DK	Do you participate in active activities	Y	N	DK
Have you had any problems associated with previous dental treatment	Y	N	DK	Have you had a serious head or mouth injury	Y	N	DK
Do you drink bottle or filtered water	Y	N	DK	Date of your last dental exam_____			
Are you currently experiencing pain/discomfort	Y	N	DK	Date of last dental x-rays_____			

What is the reason for your dental visit today?_____ How do you feel about your smile?_____

MEDICAL INFORMATION

Are you now under the care of a physician	Y	N	DK	Have you had a serious illness, operation or been hospitalized in the past 5 years	Y	N	DK
Physician Name_____				If yes, what was the illness or problem_____			
Phone _____							
Are you in good health	Y	N	DK	Are you taking or have you recently taken any prescription or over the counter medicines	Y	N	DK
Has there been any change in your general health within the past year?	Y	N	DK	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:_____			
If yes, what condition is being treated_____				_____			
Date of last physical exam_____							

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	Y	N	DK	Do you use tobacco (smoking, snuff, chew, bidis)	Y	N	DK
Scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, metastatic cancer,	Y	N	DK	WOMEN ONLY, are you:			
				Pregnant?	Y	N	DK
				Number of weeks:_____			
				Taking birth control pills or hormonal replacement	Y	N	DK
Date treatment began_____				Nursing	Y	N	DK

MEDICAL INFORMATION

Allergies: Are you allergic to or have you had a
Reaction to: Local anesthetics..... Y N DK
Aspirin..... Y N DK
Penicillin or other antibiotics..... Y N DK
Barbiturates, sedatives, or sleeping pills..... Y N DK
Sulfa drugs..... Y N DK
Codeine or other narcotics..... Y N DK

Metals..... Y N DK
Latex (rubber)..... Y N DK
Iodine..... Y N DK
Hay fever/seasonal..... Y N DK
Animals..... Y N DK
Food..... Y N DK
Other.....

Artificial (prosthetic) heart valve..... Y N DK
Damaged valves in transplanted heart..... Y N DK
Unrepaired, cyanotic CHD..... Y N DK
Repaired CHD with residual defects..... Y N DK

Previous infective endocarditis..... Y N DK
Congenital heart disease..... Y N DK
Repaired (completely) in the last 6 months..... Y N DK

Cardiovascular disease..... Y N DK
Heart attack..... Y N DK
Low blood pressure..... Y N DK
Other heart defects..... Y N DK
Rheumatic fever..... Y N DK
Anemia..... Y N DK
AIDS or HIV infection..... Y N DK
Rheumatoid arthritis..... Y N DK
Bronchitis..... Y N DK
Tuberculosis..... Y N DK
Chronic pain..... Y N DK
Malnutrition..... Y N DK
Ulcers..... Y N DK
Glaucoma..... Y N DK
Epilepsy..... Y N DK
Sleep disorder..... Y N DK
Kidney problems..... Y N DK
Persistent swollen glands..... Y N DK
Sexually transmitted disease. Y N DK

Angina..... Y N DK
Congestive heart failure..... Y N DK
Damaged heart valves..... Y N DK
Mitral valve prolapsed..... Y N DK
Rheumatic heart disease..... Y N DK
Blood transfusion..... Y N DK
Arthritis..... Y N DK
Systemic lupus..... Y N DK
Emphysema..... Y N DK
Cancer/Chemo/radiation tx... Y N DK
Diabetes Type I Type II..... Y N DK
Gastrointestinal disease..... Y N DK
Thyroid problems..... Y N DK
Hepatitis, jaundice..... Y N DK
Fainting spells, seizures..... Y N DK
Mental health disorders..... Y N DK
Night sweats..... Y N DK
Severe headaches/migraines Y N DK
Excessive urination..... Y N DK

Arteriosclerosis..... Y N DK
Heart murmur..... Y N DK
High blood pressure..... Y N DK
Pacemaker..... Y N DK
Abnormal bleeding..... Y N DK
Hemophilia..... Y N DK
Autoimmune disease..... Y N DK
Asthma..... Y N DK
Sinus trouble..... Y N DK
Chest pain upon exertion.... Y N DK
Eating disorder..... Y N DK
G.E. Reflux/heartburn..... Y N DK
Stroke..... Y N DK
Liver disease..... Y N DK
Neurological disorders..... Y N DK
Recurrent infections..... Y N DK
Osteoporosis..... Y N DK
Rapid weight loss..... Y N DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No
Name of physician or dentist making recommendation:_____ Phone:_____
Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:_____ Date_____

Recorded By:_____

Written Financial Policy

Thank you for choosing Anderson Lake Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with no insurance discount prior to completion of care.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card

- Anderson Lake Dental Discount Plan (Ask front desk for details)

Please note:

Anderson Lake Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Anderson Lake Dental charges $30 for returned checks. Anderson Lake Dental charges a missed appointment fee of $45 for all appointments that are missed or canceled without proper notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.