LAKESIDE DENTAL

Patient Information

Name_____ Date_____

Address_____

City_____ State_____ Zip Code_____

Birthday_____/_____/_____ Social Security _____ Age_____

Home Phone_____ Work Phone_____

Cell Phone_____ **Email address** _____

Where do you prefer us to contact you regarding appointments? **(Circle)** HOME/ WORK / CELL/ EMAIL

Gender_____ Marital Status_____ Preferred Name_____

Employer _____ Occupation_____

Referred by _____

In the event of emergency, who should we contact?

Name_____Relationship_____Phone#_____

Responsible Party *(Name on Insurance Card or who Insurance is through, if not you)*

Name_____Birthday_____/_____/_____

Relationship to Patient_____Social Security_____

Address_____

City_____ State_____ Zip Code_____

Employer_____ Occupation_____

Work#_____ Home or Cell #_____

Dental Insurance YES / NO Insurance Company_____

Policy #_____Group or Employee #_____

Circle which method of payment you will be using: CASH CHECK CREDIT CARD DEBIT CARD

There is a $30.00 charge for any returned checks.
There will be a 1.5% finance charge added for any unpaid balance.

_____

Patient/Responsible Party Signature:

Lakeside Dental

Medical History

Do you have or ever had:

Yes / No Heart Problems
Yes / No Liver Problems
Yes / No Kidney Problems
Yes / No Mitral Valve Prolapse
Yes / No High Blood Pressure
Yes / No Hip or Knee Replacement Date: _____
Yes / No Hepatitis A, B or C
Yes / No H.I.V.
Yes / No Diabetes
Yes / No Sinus Problems
Yes / No History of Drug Use or Abuse
Yes / No Cancer
Yes / No Are you currently taking Blood Thinners?
Yes / No Are you currently taking any daily medication? Please list: _____
_____
Yes / No Are you allergic to any medication or materials? Please list: _____
_____
Yes / No Is there any other information we should know about your medical history?
_____

FEMALES:

Yes / No Are you pregnant? Due Date: _____
Yes / No Are you taking Birth Control?

DENTAL HISTORY:

Yes / No Do you like your smile?
Yes / No Are your teeth sensitive to temperature?
Yes / No Do your gums ever bleed?
Yes / No Have you ever been given proper oral hygiene instructions?
Yes / No Have you ever worn braces?
Yes / No Have you ever had TMJ problems (Tempera Mandibular Joint)?
Yes / No Have you ever been diagnosed with periodontal disease?
Yes / No Do you, or have your ever worn a partial or denture?
Yes / No Have you ever had a reaction to local anesthesia?
Yes / No Have you ever had Botox injections or Dermal Fillers?
Yes / No Any other information we should know concerning your dental history?

_____

When was your last dental visit?_____ Why are you here today?_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in medical status.

Sign:_____Date:_____

Lakeside Dental Informed Consent

1. Examination and X-Rays

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. Changes In Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Sandras to make any or all changes and additions as necessary.

3. Fillings

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage and tooth sensitivity is a common after-effect of newly placed filling.

4. Removal Of Teeth (Extractions)

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize Dr. Sandras to extract teeth and any others necessary for the reasons in paragraph #2. I understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment.

5. Crowns, Bridges, Veneers and Bonding

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. It has been explained to me that, in few cases, tooth may develop the need for root canal treatment, which cannot always be predicted or anticipated.

6. Dentures-Complete or Partial

I realize that full or partial dentures are artificial. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage.

7. Endodontic Treatment (Root Canal)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that there will sometimes be a post placed in the tooth to help stabilize and secure the tooth.

8. Periodontal Treatment

I understand that I may have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, following a healthy diet, avoid tobacco products and follow Dentist/Hygienist recommendations.

_____ _____

Patient Signature (Parent, if child) Date

Lakeside Dental

Payment Agreement

I acknowledge and agree that I am fully responsible for payment of all charges for any dental services rendered to me, my spouse and my dependent children by the dentist or company named above and for payment of any balance not paid by insurance. As a courtesy, we will file your insurance but you, the patient, are ultimately responsible for payment of services provided, not the insurance company. Our contract is with you, the patient, not your insurance company. I further reaffirm and agree to pay all previously incurred and unpaid charges and for future charges rendered to myself and my family. I also agree to pay all reasonable collection costs, including a reasonable attorney's fee of one-third of the unpaid principal balance due on my account in the event my account is placed with an attorney for collection. I further agree to pay interest at the rate of 18% per year on the unpaid balance on my account. I waive any right I may have according to the Constitution and laws of the State of Alabama, or any other state, to claim exemptions as a personal property as to this obligation.

Authorization and Assignment

I hereby authorized the above named dental practice and their associates to furnish information to insurance carriers concerning services and treatment rendered to myself and my dependents; and I hereby assign to the said dentists all payments for such services rendered to myself, and my dependents. I understand that I am responsible for any amount not paid by insurance.

PRINTED NAME:_____

SIGNATURE:_____Date:_____

If you have any questions, please feel free to as the office personnel or the Doctor.

****PLEASE BRING INSURANCE CARD AND PICTURE ID TO THE FRONT DESK****

LAKESIDE DENTAL

HIPAA Privacy Policy / Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to us.

Please review carefully.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 8, 2007, and will remain in effect until we replace it.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer, Brandi Hatfield, at (205)343-9393.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to another dentist or health care provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend, or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state workers' compensation laws.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

NOTICE OF PATIENT RIGHTS

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and health care operations, and certain other activities for the last six years, but not before April 14, 2007. You must submit a written request that is signed and dated. **Right to Request Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Patient Rights.

_____

Patient or Patients Representative Signature Date

LAKESIDE DENTAL

Limited Warranty

In our office, we strive for technical perfection and customer satisfaction, which is why we are happy to provide you this warranty, something few other offices offer. With the information and technology we have available today, we have the ability to prevent oral disease. Instead of going to the dentist every few years for costly "drill and fill" treatment, you can actively participate in disease prevention. If you spend 5 minutes in the morning and 5 minutes in the evening brushing, flossing and doing other dentist-recommended treatments, let your dentist professionally clean your teeth, check for oral cancer, check for cavities, or apply sealants, you can prevent virtually all disease. This is why our warranties become null and void if we do not see you for your regular six-month check-ups.

Crown and Bridge Warranty

1. For a period of one year from the date of service, we will replace the crown or bridge due to breakage.

2. This warranty is null and void if the patient does not maintain his/her six-month continuing care check-up and cleaning appointments.

*****If your porcelain crown chips in the first year, we will replace or repair it for free. However, if it chips after the one-year period, you will be charged the regular fee for a new crown.

Composite Filling Warranty

1. When a tooth has a cavity, the dentist removes the decay and fills the hole with a composite or silver filling, which is ideally no more than 50% of the tooth. We will replace the resin for a period of one year from the date of service, due to breakage at no cost to the patient. However, if it chips after the one-year period, you will be charged the regular fee for a new composite.

2. This warranty is null and void if the patient does not maintain his/her six-month continuing care check-up and cleaning appointments.

Signature:_____