LAKE FOREST DENTAL

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PERSONAL

Patient Name_____

Birthdate_____ SS#_____ DL# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Cell Phone_____Email_____

Address_____ City_____

State_____ Zip_____ Home Phone_____

Emergency Contact_____ Phone _____Relationship_____

If patient is under 18 yrs, please also complete the following:

Guarantor Name_____

Birthdate_____ SS#_____ DL# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N Work Phone_____ Cell Phone_____Email_____ Preferred contact method [ ] Hm Phone [ ] Wk Phone [ ] Wireless Ph [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part time

How did you hear about us? (Please be specific so we can thank them!)_____

INSURANCE POLICY 1

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Sub. Zip Code: _____

Sub. Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

INSURANCE POLICY 2

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Sub. Zip Code: _____

Sub. Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____
Have you had any serious illnesses or operations? [ ] Yes [ ] No
If yes, describe: _____
Have you ever had a blood transfusion? [ ] Yes [ ] No
If yes, give approximate date: _____

(WOMEN) Are you pregnant? [ ] Yes [ ] No Nursing? [ ] Yes [ ] No
OB/GYN Name: _____ Phone Number: _____

Check any medical conditions you may have:

[ ] None	[ ] Diabetes	[ ] Joint Replacement, Date of: _____
[ ] AIDS/HIV	[ ] Emphysema	[ ] Kidney/Bladder Trouble
[ ] Alcohol/Drug Abuse	[ ] Epilepsy	[ ] Liver Disease
[ ] Anemia/Leukemia	[ ] Fainting Spells/Seizures	[ ] Low Blood Pressure
[ ] Anorexia/Bulimia	[ ] Fever Blisters/Herpes	[ ] Mental Health Problems
[ ] Arthritis	[ ] Frequent Headaches	[ ] Mitral Valve Prolapse
[ ] Asthma/Hay Fever	[ ] Frequently Dry Mouth/Sjogren	[ ] Persistent Diarrhea
[ ] Blood Clotting Problems	[ ] Gall Bladder Trouble	[ ] Rheumatic Fever
[ ] Blood Transfusion	[ ] Heart Attack/Stroke	[ ] Rheumatic Heart Disease
[ ] Bronchitis	[ ] Heart Disease/Angina	[ ] Sexually Transmitted Disease
[ ] Cancer/Tumor or Growth	[ ] Heart Murmur	[ ] Sinus Trouble
[ ] Cardiac Pacemaker	[ ] Hepatitis/Jaundice	[ ] Stomach Ulcers
[ ] Chest Pain Upon Exertion	[ ] High Blood Pressure	[ ] Thyroid Problems
[ ] Damage Heart Valve	[ ] Hives/Skin Rash	[ ] Tuberculosis

Tobacco use? If so, what kind and how much?_____
Unusual reaction to dental injections?_____

List all the medications or drugs you are now taking:
[ ] None
_____
_____
_____
_____

Check medications or drugs you are allergic to:

[ ] None	[ ] Local Anesthetics
[ ] Aspirin	[ ] Metals
[ ] Codeine/ Other Narcotics	[ ] Penicillin
[ ] Erythromycin	[ ] Sulfa Drugs
[ ] Latex Rubber	[ ] Other: _____

Reason for today's visit: _____Are you in pain? Yes / No
Name of former dentist_____ City/State_____
Date of last cleaning and exam_____

I certify that I, and/or my dependent(s), have dental insurance coverage and assign direction to Lake Forest Dental PA, Dr. Davina Prida, Dr. Rebecca Reyes and Dr. Kaivan Afkami all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-names dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.
I certify that the information above is correct and complete.

_____ _____
Please print name of patient, parent, guardian or personal representative. Date

_____ Doctor's Signature: _____
Signature of patient, guardian or personal representative

LAKE FOREST DENTAL
FAMILY & COSMETIC DENTISTRY

TO ALL OUR PATIENTS

IN EFFORT TO KEEP DENTAL COSTS DOWN WHILE MAITAINING A HIGH LEVEL OF PROFESSIONAL CARE, WE HAVE ESTABLISHED THE FOLLOWING INFORMED CONSENT FOR OUR PATIENTS. WE ENCOURAGE OUR PATIENTS TO DISCUSS ANY QUESTIONS THEY MAY HAVE REGARDING OUR POLICES.

FINANCIAL POLICY:

1) Payment in FULL at the time of visit is due.
2) We accept cash, Care Credit and all major credit cards ONLY.
3) If you have dental insurance, which provides coverage for this provider, we will be happy to help determine the coverage you have available.
4) Keep in mind however: your insurance policy is a contract between you and your insurance company. We, therefore, cannot guarantee payment of your claims or accept responsibility of negotiation with insurance companies or other persons.
5) If your insurance has not paid or denied your claim in 45 days, you are responsible for full payment of all unpaid claims.
6) For any balances over 60 days, interest will accumulate at the rate of 1% per month.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SERVICE. FEES ARE SUBJECT TO CHANGE EVERY YEAR.

DELINQUENT ACCOUNTS will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees/ attorney's fees.

NO-SHOW AND CANCELLATION POLICY: Your visit has been reserved for you and the dentist; a 48-hour notice is required in advance for cancellations in order to allow all our patients to receive the best possible dental care. There will be a fee if no notice is received.

I hereby authorize the release of any dental information necessary to process claims. I authorize the payment of benefits to the dentist described herein for services rendered.

DENTAL SERVICE AGREEMENT: I hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate. I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

CONSENT FOR PHOTO RELEASE: I grant Lake Forest Dental PA the right to take photographs of me and my family. I agree that Lake Forest Dental PA may use such photographs with or without my name for lawful purposes, including clinical chart reviews, communication with dental laboratories, communication with other dental specialists and professionals, illustration, advertising and web content. Should I wish to send these photographs to other dental care providers, I shall formally request them in writing as is required by the State Dental Board of Texas for transfer of records.

STATEMENT OF UNDERSTANDING:

I HAVE READ AND UNDERSTAND THIS INFORMATION SHEET AND INFORMED CONSENT.

_____ _____
Please print name of patient Date of Birth

_____
Please print name of parent, guardian or personal representative.

_____ _____
Signature of patient, guardian or personal representative Date

INFORMED CONSENT FOR DENTAL EXAM, X-RAYS, MEDICATIONS, CHANGES IN TREATMENT PLAN, PROPHYLAXIS, FLUORIDE TREATMENT, ANESTHESIA, & NITROUS OXIDE

PATIENT: _____ DATE OF BIRTH: _____

DENTAL EXAMINATION AND X-RAYS

- I understand that regular dental exams and x-rays are needed to complete the examination diagnosis and treatment plan. X-rays are an important diagnostic tool for the dentist. Many diseases of the teeth and surrounding tissues cannot be seen visually. An x-ray may reveal the presence of caries between the teeth, infections in the bone, abscesses, cysts, and other items which cannot be seen visually. Risks from radiation exposure have been significantly reduced by improvements in technology. I understand if I choose not to allow x-rays to be taken, the dentist cannot formulate an accurate diagnosis and treatment plan.

Initial_____

MEDICATIONS

- I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Initial_____

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 the teeth that were not discovered during examination (the most common being root canal therapy following routine restorative procedures). I give my dentist permission to make any/all changes and additions as necessary.

Initial_____

PROPHYLAXIS (CLEANING) AND FLUORIDE TREATMENT

- Regular dental prophylaxis plays an important role in proper dental health. Prophylaxis includes removal of soft and hard deposits on teeth, and teeth polishing with prophy paste. Risks include, but not limited to, sensitivity or bleeding of the teeth or gums. Fluoride is applied topically as a gel or paste. Fluoride helps to prevent tooth caries by making teeth stronger and is considered safe when properly used. Ingestion of high concentration can lead to nausea and/or vomiting.

Initial_____

LOCAL ANESTHETICS

- I understand that the administration of local anesthetic may cause an adverse reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary, or rarely permanent, numbness. I understand that occasionally needles break and may require surgical removal.

Initial_____

NITROUS OXIDE (LAUGHING GAS)

- Nitrous oxide is a mild gas that is a mixed with oxygen and is used to sedate a person. It is administered through a mask placed over the nose. I elect to have nitrous oxide in conjunction with the dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are limited to, nausea, vomiting, dizziness, and headache. I understand that nitrous oxide is **not indicated if I am/might be pregnant** or have had ophthalmic surgery (retinal surgery) with medical specialty gas C3F8 (pefluoroprane-SF6 (sulfur hexafluoride).

Initial_____

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Patient's or Legal Guardian's Signature Date

_____ _____

Witness to Patient's Signature Date

I, Dr. _____, DMD certify that I have explained to the above patient the ramifications of the above treatment initialed by the patient to the best of my professional ability. I further certify that in my opinion, the above patient is fully informed of the risks and possible benefits of the particular procedure agreed upon.