WELCOME!

Please take a few minutes to fill out the following forms as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you on your journey to a healthy smile!

Patient Information

Name ____ Birthdate ___/___/______ Age ____
Last Name *First Name* *Initial*
Address ____
City ______________________ State______ Zip ____________ Home Phone ________________
Cell Phone ____________________ Email ______________________________________
Sex: ☐ M ☐ F Social Security # ________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Employer _______________________ Occupation _____________ Business Phone ____________
Whom may we thank for referring you? ____
☐Website ☐Radio ☐Vivo/Valpak ☐Insurance Co. ☐Family/Friend ☐Other _____________________
Emergency contact ________________________________ Relationship____________________
Contact Phone _______________________

Primary Dental Insurance

☐ Same as above Subscriber Name ____
Last Name *First Name* *Initial*
Relation to Patient ______________________ Birthdate ___/___/______ Soc. Sec. # _______________
Address (if different from patient) ______________________________ Home Phone ______________
City _____________________________ State _______________ Zip ___________________
Cell Phone __________________ Email ____
Employer ____ Occupation _____________
Insurance Company _______________________________________ Phone __________________
Subscriber ID # ________________________________ Group # _________________________

Additional Dental Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name ____________________ Relation to patient _______________ Birthday ___/___/_____
Home Phone _________________ Cell Phone_________________ Soc. Sec. # _________________
Insurance Company ____________________________________ Phone ____________________
Subscriber ID # ________________________________ Group # _________________________

Authorization

♦ I have reviewed the information, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

♦ I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

♦ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____ Date ___________________

GENERAL HEALTH INFORMATION

DATE: _______________
PATIENT NAME: ____ BIRTHDATE ___/___/______ AGE ______________

DENTAL HISTORY

Reason for Visit/Main Concern? ☐ Check-up ☐ Cleaning ☐ Toothache ☐ Other: ____________________________________

Are there other conditions of which we should be aware? ☐YES ☐NO If yes, please specify: ____________________________
When did you last visit a dentist?____________________ What treatment was performed? ____________________________
Was that treatment completed? ______________________________________ When were dental x-rays taken? ___________________

Did you have a cleaning? ☐YES ☐NO Have you had gum (periodontal) treatment? ☐YES ☐NO

Have you ever had prolonged bleeding after an extraction? ☐YES ☐NO If yes, please specify: __________________________

Have you ever had problems with past dental treatment? ☐YES ☐NO If yes, please specify: __________________________

Do you grind your teeth, clench your jaws, or have symptoms near your ears such a clicking, popping, pain or locking open?
☐YES ☐NO If yes, please specify: ____

Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? ☐YES ☐NO
If yes, please specify: ____

Do your gums bleed easily? ☐Y ☐N Do you feel you have bad breath? ☐Y ☐N Are your teeth sensitive to hot or cold? ☐Y ☐N

Would you like your teeth whiter? ☐Y ☐N Are you happy with your smile? ☐Y ☐N If no, please specify: ____________________

MEDICAL HISTORY

Are you under a Doctor's care at this time? ☐YES ☐NO
If yes, what is your Doctor's name? ____ Phone Number ____________________
Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine?____________________
Are you taking any medications at this time, including birth control? ☐YES ☐NO If yes, please specify: ____________________
____

(Women) Are you pregnant now? ☐YES ☐NO If yes, how many months? _________________________ Are you nursing? ☐YES ☐NO
Are there any other health problems of which we should be advised? Please specify: ______________________________________

Check (✓) yes or no whether you have or have had any of the following:

☐ Y ☐ N ARTIFICIAL HEART VALVE
☐ Y ☐ N AIDS/HIV +
☐ Y ☐ N ANEMIA
☐ Y ☐ N ANGINA
☐ Y ☐ N ARTHRITIS
☐ Y ☐ N ASTHMA
☐ Y ☐ N BIPHOSPHONATE THERAPY
☐ Y ☐ N BLEEDING PROBLEMS
☐ Y ☐ N CANCER
☐ Y ☐ N CHEMO/RAD THERAPY
☐ Y ☐ N COSMETIC SURGERY
☐ Y ☐ N DIABETES
☐ Y ☐ N DIZZY SPELLS
☐ Y ☐ N DRUG ADDICTION

☐ Y ☐ N EMPHYSEMA
☐ Y ☐ N EPILEPSY
☐ Y ☐ N FAINTING
☐ Y ☐ N GLAUCOMA
☐ Y ☐ N HEART ATTACK/SURGERY
☐ Y ☐ N HEART PROBLEMS
Describe: _______________________
☐ Y ☐ N HEPATITIS
☐ Y ☐ N HIGH BLOOD PRESSURE
☐ Y ☐ N JAUNDICE
☐ Y ☐ N JOINT REPLACEMENT
☐ Y ☐ N KIDNEY DISEASE
☐ Y ☐ N LATEX ALLERGY
☐ Y ☐ N LIVER PROBLEMS

☐ Y ☐ N LOW BLOOD PRESSURE
☐ Y ☐ N LUNG DISEASE
☐ Y ☐ N PACEMAKER
☐ Y ☐ N PSYCHIATRIC CARE
☐ Y ☐ N RHEUMATIC FEVER
☐ Y ☐ N SHINGLES
☐ Y ☐ N SINUS TROUBLE
☐ Y ☐ N SLEEP APNEA
☐ Y ☐ N TOBACCO
☐ Y ☐ N STROKE
☐ Y ☐ N THYROID PROBLEMS
☐ Y ☐ N TMD OR TMJ
☐ Y ☐ N TUBERCULOSIS
☐ Y ☐ N VENEREAL DISEASE

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature ____ **Date** ________________________
(Parent signature if patient is a minor)
Doctor Signature __________________________________

MEDICAL UPDATE:

1. Patients signature ____ Doctor's Signature _______________ Date_______________
2. Patients signature ____ Doctor's Signature _______________ Date_______________

LAKEVIEW SMILES FINANCIAL INFORMATION

Any estimated amounts due and payable by the patient (including co-pays and deductible) are required to be paid on or before the day the services are performed. You are responsible for all charges incurred on your account.

METHODS OF PAYMENT

1. Cash or Check
2. Visa, MasterCard, American Express & Discover
3. Dental Benefits
4. Flex Spending/ HSA Cards
5. Lending Club or CareCredit (3rd party financing)

APPOINTMENT AND CANCELLATION POLICY

A broken appointment is a loss to everyone. Remember, once you have made an appointment, this is time reserved for you. Please give us at least 48 hours' notice if you are unable to keep your appointment. This will allow us to accommodate the needs of other patients more readily. If we do not receive a cancellation notice within 24 hours, a cancellation fee of $25 per hour may be applied to your account. Please note that our voicemail does not accept cancellations after 24 hours. **Initials**__________

PATIENTS WITH INSURANCE

We are pleased that many of you have dental benefits and our office will assist you in obtaining the maximum benefits specified in your contract. However, your benefits are a contract between you, your employer and an insurance carrier. We will assist you in determining your benefits as best we can. Because plans differ from carrier to carrier and policy to policy, our office may refer you to your insurance company or your employer's benefits coordinator for assistance in understanding your plan.

- As a courtesy to you, we will file your benefit claim forms and accept assignment of benefits. We ask that your estimated co-payments and deductible be paid at the time of service.
- Balances with benefit claims outstanding more than 90 days may be reverted back to the patient.
- Not all services are a covered benefit in all contracts. Some carriers and employers select only some services to be covered. You are responsible for payment of all services regardless of the payable benefit.

AUTHORIZATION TO RELEASE INFORMATION AND ACCEPT ASSIGNMENT OF BENEFITS

I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or unless Benjamin Dorantes, DDS has a contractual agreement with my dental plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information (PHI) to carry out payment activities in connection with any and all claims. I understand and authorize that this form remain in effect provided that I am a patient of record with Benjamin Dorantes, DDS doing business as Lakeview Smiles Family Dentistry. **Initials**__________

Signature: ____**Date:** ________________________________

(*This entire document shall be enforceable without initials above.)*

Lakeview Smiles
FAMILY DENTISTRY

ACKNOWLEDGEMENT OF
RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Lakeview Smiles Family Dentistry. The statement of Privacy Practices describes the types of uses and disclosures of my protected health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lakeview Smiles Family Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPPA rules.)

Spouse/Domestic partner only	YES ☐	NO ☐
Any member of my immediate family: (Spouse, Children, Children's Spouses)	YES ☐	NO ☐
Any member of my extended family: (Parents and Grandchildren)	YES ☐	NO ☐
Other: ____	YES ☐	NO ☐

- Name of Patient: (Please print) ____
- Patient signature (if over 18 years old) ____
- Guardian or Representative (Please print) ____
- Guardian or Representative Signature ____

For Office Use Only

Acknowledgement Not Obtained

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)
- ____

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1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand that I will be presented with a treatment plan following Dr. Dorantes' exam.

(Initials: __________)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and 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. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

(Initials: __________)

3. 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 the examination, the most common being root canal therapy following routine restorative procedures. I give permission to the Dentist to make any/all changes and additions as necessary.

(Initials: __________)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials: __________)

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials: __________)

6. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance claims and receiving a benefit is my responsibility and acknowledge that Lakeview Smiles only does this as a courtesy for me. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials: __________)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

PRINT NAME: ________________________________ **DATE:** ________________________

SIGNATURE: ________________________________ **DOCTOR:** ______________________

(*This entire document shall be enforceable without initials above.)*