PATIENT REGISTRATION

FIRST NAME_____ LAST NAME_____ MIDDLE INITIAL_____

BIRTHDATE_____ AGE_____ MALE_____ FEMALE _____ REFERRED BY_____

ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

HOME PHONE_____ WORK PHONE_____ EXT_____ CELL_____

EMAIL_____ MINOR____ SINGLE____ MARRIED____ DIVORCED____ SEPARATED____ WIDOWED____

EMPLOYER_____ POSITION_____ SOC SEC_____

SPOUSE FULL NAME_____ BIRTHDATE_____ CELL_____

SPOUSE EMPLOYER_____ POSITION_____ WORK PHONE_____ EXT_____

NAME OF EMERGENCY CONTACT: NEAREST RELATIVE NOT LIVING WITH YOU_____ PHONE_____

MINOR INFORMATION

FATHER'S FULL NAME_____ BIRTH DATE_____ CELL_____ SOC SEC_____

FATHER'S EMPLOYER_____ POSITION_____ WORK PHONE_____ EXT_____

MOTHER'S FULL NAME_____ BIRTH DATE_____ CELL_____ SOC SEC_____

MOTHER'S EMPLOYER_____ POSITION_____ WORK PHONE_____ EXT_____

PRIMARY DENTAL INSURANCE

NAME OF SUBSCRIBER_____ BIRTH DATE_____ SOC SEC_____

INS.COMPANY_____ ADDRESS_____ CITY_____ STATE_____ ZIP_____

ID #_____ GROUP #_____ MAXIMUM BENEFIT PER YEAR_____ DEDUCTIBLE_____

RELATIONSHIP TO SUBSCRIBER_____SELF_____SPOUSE_____CHILD_____OTHER

SECONDARY DENTAL INSURANCE

NAME OF SUBSCRIBER_____ BIRTH DATE_____ SOC SEC_____

INS. COMPANY_____ ADDRESS_____ CITY_____ STATE_____ ZIP_____

ID #_____ GROUP #_____ MAXIMUM BENEFIT PER YEAR_____ DEDUCTIBLE_____

RELATIONSHIP TO SUBSCRIBER_____SELF_____SPOUSE_____CHILD_____OTHER

SIGNATURE OF RESPONSIBLE PARTY_____ DATE_____
(PARENT OR GUARDIAN IF PATIENT IS A MINOR)

CONSENT / AUTHORIZATION FOR DENTAL TREATMENT OF A MINOR

Patient Name: _____ Date of Birth: _____

All minors seeking dental treatment must be accompanied by a parent/legal guardian during the **initial office visit.** After the initial appointment, a minor may be seen for treatment only with written authorization from the parent/guardian under the conditions specified in this consent. *If the parent/legal guardian **cannot attend** the appointment, the following instructions that you select will be adhered to in the treatment of the minor patient (check all that apply):

- Permission for Lake Dental Care to treat my child while I am not present (cleanings and/or dental work) and if other tx or decayed surface is found: □ **Go ahead and treat** OR □ **Contact parent**

□ the consent for signing any and all forms required to give permission to Lake Dental Care to treat the dental needs of my child

□ the consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges)

□ the consent to the dental practice to discuss my child's future dental treatment needs (ie. treatment plans)

□ the consent to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child

□ the consent to schedule future dental visits for my child

If you need to send your child to their appointment with an adult other than yourself/legal guardian, please complete this section:

I appoint the following adult _____, whose relationship to the minor is _____, to consent to dental treatment which is deemed necessary by Lake Dental Care as authorized herein. A parent/legal guardian may appoint another adult to accompany the minor patient to the appointment. If the parent/legal guardian is not available, the Minnesota Family Code allows only certain adults to consent for medical treatment to minors if parental consent cannot be obtained. These are: a grandparent, an adult brother, sister, aunt or uncle, and any adult who has actual care, control, and possession of the minor and has written authorization to consent from the parent/legal guardian.

I, _____, am the parent/legal guardian of the minor child _____. I have the legal right to consent for medical treatment for this patient. I hereby authorize Lake Dental Care to provide dental treatment as indicated above. **I understand this consent will be valid for one year or until I rescind this agreement in writing.**

*** I understand I am responsible for all charges or fees incurred and co-payments must be made at the time of service as our financial policy states. We will gladly process payments over the phone if a credit card is used.**

_____

Parent/Guardian Signature Parent/Guardian Printed Name Date

Time 10:08 AM | Lake Dental Care | Date 4/2/2019

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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 Patient, Parent or Guardian:

X Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Lake Dental Care

810 Martin Ave.

Big Lake, MN 55309

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Lake Dental Care's *HIPAA Notice of Privacy Practices*.

I understand that Lake Dental Care's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Lake Dental Care's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Lake Dental Care's *HIPAA Notice of Privacy Practices*, I may contact Michelle Carlson or Dr. Kyle Skjei.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Lake Dental Care will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Lake Dental Care's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Michelle Carlson or Dr. Kyle Skjei, noted above, for assistance.

_____ Patient Signature

_____ Date

_____ Signature of Personal Representative

_____ Print Name of Personal Representative

_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Lake Dental Care made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Lake Dental Care was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

Lake Dental Care Financial Policies and Options

In addition to providing the highest quality of dental care available, we are dedicated to making the premium dental care as cost effective as possible. . e are sensitive to your financial needs. In order to assist you with your healthcare investment, we offer flexible payment options.

Patients are expected to pay all fees when dental services are provided. For our patients with dental insurance coverage, only their estimated portion is due when provided. After examination and diagnosis, a complete description of the required treatment and written proposed treatment plan will be provided to the patient.

If the patient's dental treatment plan is greater than $300, a payment must be arranged regardless of any insurance benefit. Our patient care coordinator will be happy to assist you, and set up a payment arrangement best suited for your financial concerns.

Dental Insurance

Lake Dental Care is a provider for many major insurance companies. Since every insurance plan is different, please be sure to check your coverage and ask any questions you might have before your appointment. Most insurance companies will not cover 100% of your dental service. Patient portion not covered by insurance is due at the time treatment is provided.

Flexible Payment Options

1. Cash or Check: *we offer a 5% discount for uninsured patients who pay in full same day services are provided. *For uninsured patients 65 years or older, we offer a 10% senior discount. (No discount with Debit Cards)
2. We accept Visa, MaterCard, and Discover (no discount with Credit Cards).
3. 90 day payment plan option with Lake Dental Care (1st payment 1/3 of patient estimated portion is due when treatment is started) our office will not finance past 90 days.
4. CareCredit or Lending Club for patients who would like to extend payments past 90 days (subject to credit approval).

*A finance charge of 1.5% per month (18% per year) will be applicable on account balances after 90 days.

Billing Statement

We will send a billing statement to all our patients, insured or uninsured, if you have a balance. If your insurance company hasn't paid on claim after 30 days, please contact them and find out why. After contacting your insurance company and you need further assistance, please do not hesitate to call. Payment is due in full upon receipt unless a payment arrangement has been made.

I acknowledge that I have read the financial policies and options information and agree to the terms and conditions herein.

Patient Name _____ Date _____

Signature of Responsible Party _____