PATIENT REGISTRATION

FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

BIRTHDATE _____ AGE _____ MALE _____ FEMALE _____ REFERRED BY _____

ADDRESS _____ CITY _____ STATE _____ ZIPCODE _____

HOME PHONE _____ WORK PHONE _____ EXT _____ CELL _____

EMAIL _____ MINOR _____ SINGLE _____ MARRIED _____ SEPARATED _____ WIDOWED _____

EMPLOYER _____ POSITION _____ SOC SEC _____

SPOUSE'S FULL NAME _____ BIRTHDATE _____ CELL _____

SPOUSE EMPLOYER _____ POSITION _____ WORK PHONE _____

NAME OF EMERGENCY CONTACT: (Nearest relative, not living with you) _____ PHONE _____

MINOR INFORMATION

FATHER'S FULL NAME _____ BIRTHDATE _____ CELL _____ SOC SEC _____

FATHER'S EMPLOYER _____ POSITION _____ WORK PHONE _____ EXT _____

MOTHER'S FULL NAME _____ BIRTHDATE _____ 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 _____

AUTHORIZATION PLEASE READ CAREGULLY AND SIGN

I hereby authorize release of information necessary to file a claim with my insurance company and authorize payment directly to Lake Dental Care of insurance benefits otherwise payable to me. I understand that my dental insurance company may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts.

I understand that a finance charge of 1.5% per month (18% per year) will be charged on my balance over 90 days.

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

SIGNNATURE OF RESPONSIBLE PARTY _____ DATE _____

(PARENT OR GUARDIAN IF PATIENT IS A MINOR)

Lake Dental Care - Medical History

Patient Name: _____ Birth Date: _____ Date Created: _____

Although dental personnel primarily treat the area in and around y our mouth, your mouth is part of your entire body. Please let us know of any health problems that you may have, or any medication you might be taking.

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, Fen-Phen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco products?	○ Yes ○ No	

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

Do you use controlled substances?	○ Yes ○ No	If yes
Other drugs or medications?	○ Yes ○ No	If yes

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

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

Have you had any other health issues or serious illness not listed? 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 my 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: _____

Lake Dental Care
ACKNOWLEDGEMENT AND CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____

TELEPHONE (H): _____ CELL: _____

EMAIL: _____

SECTION B TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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.

PURPOSE OF ACKNOWLEDGEMENT: By signing this form you acknowledge you had the opportunity to read our Notice of Privacy Act for Lake Dental Care Office.

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 Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kathy Tindell
Telephone: 763-262-0259
Address: 751 Rose Dr., Suite 105, Big Lake, MN 55309

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 this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this 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 healthcare operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.

REVOCATION OF CONSENT: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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. We 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.

As a courtesy to our insured patients after examination and diagnosis, we will submit a preauthorization to your insurance company. When your insurance company has notified us of your estimated coverage, we will contact you to go over figures and set up a payment plan. Please remember that a preauthorization is never a guarantee of payment. Patients will always be responsible for their total fees should their insurance result in less coverage than anticipated. The patient is still the responsible party for all dental fees.

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 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 balance 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 our assistance, please do not hesitate to call. Payment is due in full upon receipt unless payment arrangement has been made.

Patient Name _____

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

Signature of Responsible Party _____ Date _____