PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____ _____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)
☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)
Card # _____ Exp. Date _____
☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

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ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Nickname:
Date of Birth: / /	Gender:		
Parent's/Guardian's Name:		Relationship to Patient:	
Email Address:			
Home Phone:	Cell Phone:	Work Phone:	
Mailing Address:	City:	State:	Zip:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had? ☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where? _____

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? _____ What was done at that appointment? _____

When was the last time the patient had dental x-rays taken?

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: _____	☐	☐	☐
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____	☐	☐	☐
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: _____	☐	☐	☐
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: _____	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____	☐	☐	☐
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			

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Form S70726 To reorder call 800.947.4746 or go to ADAstore.org.

Live Oak Family Dentistry
Office Policies

Dental treatment is an excellent investment in an individual's overall health and well-being. We are committed to helping our patients optimize their overall health. Following a thorough assessment, a treatment plan will be created to address your specific dental needs. This plan is not influenced by any insurance benefits that you may have.

Payment Policy:
Payment is due at the time service is provided. Our office accepts cash, personal check, debit/credit cards, and outside patient financing like Care Credit.

Our office is **NOT** under contract **(NOT IN NET-WORK)** with any insurance company.
_____initial

Insurance Policy:
If you have dental insurance, your policy is an agreement between you and your insurance company. We will always do our best to help you maximize your benefits. As a courtesy, we will file your insurance claim, **but we can make no guarantee of any estimated coverage.** Please understand that you are responsible for paying any charges not covered by insurance. _____initial.

Cancellation/No Show Policy:

Our goal is to provide our patients with quality dental care and the personal attention they deserve. Your appointment time is reserved just for you. If you need to cancel your appointment, please notify us at least 24 hours in advance. Same day cancellations will be considered the same as a no-show and a $50.00 broken appointment fee maybe assessed to your account. Please understand that with advanced notification, your unused appointment time could be used to help someone else. _____initial

I have read, understand and agree to the above office policies. I have given and agreed to provide current demographic and insurance information and authorize release of information necessary for insurance filling, if applicable. By signing the statement, I also authorize my insurance company to pay my dental benefits directly to my dental office.

_____	_____	_____
Date	Print Patient Name	Patient Signature

LIVE OAK FAMILY DENTISTRY

PATIENT CONSENT FORM (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

2. Obtaining payment from third party payers (e.g. my insurance company)

3. The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under **HIPAA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name:_____Date:_____

Relationship to Patient:_____

Signature:_____

LIVE OAK FAMILY DENTISTRY
HIPAA RELEASE FORM

I,_____, authorize the release of information of
(PRINT PATIENT/GUARDIAN NAME)

_____, including the diagnosis, records,
(PATIENT NAME)

examination and treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to (Check one):

( ) Spouse_____

( ) Child(ren)_____

() Other_____

( ) Information is not to be released to anyone. (Initial Here_____

In further consideration for this, Live Oak Family Dentistry agrees to the same stipulations. This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date_____ /_____/_____

Witness:_____ Date_____ /_____/_____