Northside
Family Dental

Frank Laga DMD

6731 US Hwy 98 N, Lakeland, FL 33809 • (863) 858-3043 • frontdesk@northlakelandsmiles.com • www.northlakelandsmiles.com

Today's Date: _____ How did you hear about us?_____

Patient Registration

Patient's Name: _____ DOB: _____ SS#_____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Preferred Method of contact: __ Text __ Call __ Email
Address: _____
City: _____ Zip: _____
Spouse/ Guardian Name: _____ DOB: _____
Spouse/ Guardian Phone #: _____
Spouse/ Guardian SS# (if they are the policy holder) _____

Emergency Contact: (if different from Spouse/ Guardian above)
Name:_____ Relationship: _____
Telephone number: _____
Primary Physician Name and Office: _____
Primary Physician Phone Number _____

Insurance Information

Name of Insured: _____ Birthdate: _____ SS#:_____
Insurance Company:_____ Policy ID:_____
Ins Co. Address:_____ Group#_____
Name/address of employer: _____
Work Phone: _____

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OFFICE GUIDELINES

We realize that every person's financial situation is different. For this reason, we have worked very hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile in a personalized and comfortable setting.

Consent

I authorize the doctors to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangement will be agreed upon before treatment has begun.

If care is being rendered on a **minor child**, I authorize the doctor to obtain x-rays and to treat my child as needed. I understand I will be given the opportunity to discuss the treatment with the doctor and that the parent or guardian who accompanies the child to the office is responsible for payment.

Financial Responsibility

1. In the event of default, I am responsible to pay legal interest on the indebtedness, collection cost, and related attorneys' fees
2. There is a $35 charge for all returned checks
3. There is a $50 charge per hour charge for broken/ cancelled appointment not allowing a 48 hour notice

Dental Insurance

We are happy to file forms necessary to see that you receive the full benefits of your coverage, however, **we cannot guarantee any estimated coverage**. Unless prior arrangements are made, you will be expected to pay your portion of the services provided to you. Please keep in mind that we can only **estimate** your portion. If there is a difference after your insurance company had paid, **it is your responsibility to pay the difference**. Because the **insurance policy is a contract between you and the insurance company**, we will not enter into a dispute with your insurance company over your claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits. **Any balance not paid by the insurance company within 60 days of submission becomes the patient's responsibility to pay at that time.**

Payment Options

1. Cash or check
2. Credit card: for your convenience, we have made arrangement to accept payment by several major credit cards such as VISA, MASTER and DISCOVER.
3. If multiple appointments are required for your dental treatment, you may pay **60% of your total balance** at the start of treatment and the **balance upon completion**.

Signature: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT for our staff to discuss treatment or finances with the following person. Example: parent, spouse, child, etc. If none, write NONE.

Name:_____Telephone: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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.

Notice of Privacy Practices: 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). HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

We reserve the right to change our 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.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice. 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 heath care 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: _____

TIME 10:43 AM

DATE 7/12/2011

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

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 Problem ◯ 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 _____

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 _____ DATE _____