LAKE ARBOR
DENTAL & ORTHODONTICS

To aid us in providing diagnosis and treatment for your dental needs, please completely fill out this confidential questionnaire.

Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
E-Mail Address: _____ Social Security #: _____
Mailing Address: _____ Home Phone #: _____
_____ Cell Phone #: _____
City State Zip Code Work Phone #: _____

INSURANCE INFORMATION/PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Date of Birth: _____
Relationship to Patient: _____ Employer: _____
Dental Insurance Carrier: _____
Social Security # or Identification #: _____ Group #: _____

Please, whom may we thank for referring you to our office: _____

HEALTH HISTORY

Name of family physician: _____ Location: _____
How is your general health? EXCELLENT GOOD FAIR POOR

Do you have or have you ever had any of the following? Please circle.

Heart Disease	Diabetes	Tumor History	Liver Disease
AIDS	Stroke	Ulcers	Allergies
Epilepsy	Asthma	Blood Disorder	Tuberculosis
Hepatitis	Sinus Trouble	Fainting	Rheumatic Fever
Anemia	Arthritis	Heart Murmur	Emphysema
Thyroid Disease	Kidney Disease	Radiation	Psychiatric Treatment
High Blood Pressure	Venereal Disease	Sleep Apnea	Mitral Valve Prolapse

Have you ever had a joint replaced? YES NO
If yes, please explain: _____
Have you ever been hospitalized and/or had surgery within the last five years? YES NO
If yes, please explain: _____
Are you under the care of any physician now? YES NO
If yes, please explain: _____
Are you taking any medication, drugs or pills? YES NO
If yes, please list: _____
Are you allergic or sensitive to penicillin or any other medication? YES NO
If yes, please list: _____

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Do you have any disease, condition or problem not listed above? YES NO
If yes, please list: _____
Do you smoke? YES NO
Women: Are you pregnant? YES NO
If yes, what is your due date? _____

DENTAL HISTORY

Are you currently in discomfort requiring our immediate attention? YES NO
If yes, please explain: _____
Have you had regular dental checkups? YES NO
When was your last visit? _____ What was done then? _____
Do your gums bleed when brushing or flossing? YES NO
Have you lost multiple teeth? YES NO
If yes, please explain why? _____
Are you apprehensive about receiving dental treatment? YES NO
Have there been any complications during previous dental treatment? YES NO
If yes, please explain: _____
Do you have frequent headaches? YES NO
Do you clench or grind your teeth during wake or sleep? YES NO
Do your jaws feel tired or sore when you're awake? YES NO
Do your jaw joints grind, pop, click or lock? YES NO
Have you ever been diagnosed with sleep apnea? YES NO
Do you feel tired or fatigued throughout the day? YES NO
Do you snore? YES NO
Have you ever had Botox treatments in the past? YES NO
Have you ever considered having Botox treatments? YES NO
Is there anything you would change about your smile? YES NO
Please explain: _____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergencies. These procedures may include radiographs, models and intraoral examination. In case of a dental emergency, I consent to treatment as deemed as necessary by the doctor, understanding that procedures will be explained in advance, I give my consent to the use of local anesthetics and relaxants for completing the necessary dental treatment.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE POLICY

_____

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE DATE

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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. The following is a statement of our financial policy, which we require you to read, agree and sign prior to treatment.

PAYMENT

We require payment in full at the time of service. For your convenience we accept cash, personal checks, Visa, MasterCard, Discover and American Express. We also offer a payment plan through Care Credit or Chase, which will be reviewed with you prior to your treatment. Please understand that payment of your bill is considered part of your treatment, and you will be required to make financial arrangements prior to any work being performed.

INSURANCE

Submission: As a courtesy we will prepare and submit your insurance forms for reimbursement if we have been given all of the necessary information for submission. We cannot bill your insurance company unless you bring in all of your insurance information. Please keep the following in mind:

- The balance is your responsibility whether your insurance company pays or not
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
- Please be aware that some and perhaps all of the dental services performed by Lake Arbor Dental and Orthodontics may be "non-covered" services and not considered reasonable and necessary under your dental contract

Patient Portion: Your patient portion will be estimated and due on the day of service. This estimate is based on information received by our staff from your insurance company and is only an approximate amount. Patient portions which are underestimated will be billed immediately after payment is received from your insurance company. Overpayments on accounts will be refunded to the patient. Account balances over 30 days will be subject to additional fees and interest charges of 1.5% per month. Checks which do not clear with your bank will be assessed a $25.00 service charge for reprocessing. Once a check does not clear your bank account, it will no longer be considered as an acceptable form of payment. Account balances that are not satisfied as agreed will be turned over to a collection agency and will be subject to a 30% fee.

I have read the above and understand and agree to the financial policy

_____ _____

PATIENT SIGNATURE/LEGAL GUARDIAN SIGNATURE **DATE**

_____

PRINT PATIENT NAME

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