Lake Lucerne
LIFESTYLE DENTISTRY

NEW PATIENT FORM

PERSONAL INFORMATION (MANDATORY FOR ALL PATIENTS)

PATIENT NAME		REFERRED BY:		TODAY'S DATE:	
ADDRESS		CITY/STATE		ZIP CODE	
GENDER (MALE/FEMALE)		STATUS (MARRIED, SINGLE, CHILD)		DATE OF BIRTH:	
WORK EMAIL		PERSONAL EMAIL:		SOC SECURITY:	
PREFERRED TELEPHONE NBR		DRIVERS LICENSE NBR:			

IN CASE OF EMERGENCY (MANDATORY FOR SURGICAL PATIENTS)

EMPLOYER		EMPL ADDRESS		EMPL PHONE	
PRIMARY PHYSICIAN		PHYSICIAN ADDRESS		PHYSICIAN PHONE	
PREFERRED PHARMACY		PHARM ADDRESS		PHARM PHONE	
EMERG CONTACT NAME		CONTACT RELATIONSHIP		EMERG PHONE NBR	

DENTAL INSURANCE (INSURANCE PATIENTS ONLY)

INSURANCE PROVIDER		INSURANCE ADDRESS		INSURANCE PHONE	
GROUP NBR		PAYOR NBR		SUBSCRIBER ID	
PRIMARY INSURED		PRIMARY SOCIAL SEC NBR		PRIM BIRTH DATE	

SIGNATURE: X _____

I acknowledge this information is complete and accurate to the best of my knowledge. It is my responsibility to inform the office of any changes to my personal/insurance info. I will not hold the dentist of his staff responsible for errors or omissions that I may have made in completing this form. I authorize the delivery of services I may need, with my informed

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MEDICAL / DENTAL QUESTIONNAIRE

MEDICAL HISTORY

Are you in good health? YES NO
Explain:

When was your last medical exam? _____

Are you under medical care? YES NO
Explain:

Any recent hospitalization? YES NO
Explain:

Do you smoke? YES NO

Are you pregnant/nursing? YES NO
Explain:

MEDICATIONS (LIST EACH & DOSAGE)		ALLERGIES (CIRCLE ALL THAT APPLY)	
		Antibiotics? Y / N	Sulfa Drugs? Y / N
		Barbiturates? Y / N	Aspirin? Y / N
		Anesthetics? Y / N	**Other:**
		Iodine? Y / N	
		Latex? Y / N	
		Narcotics? Y / N	

MEDICAL CONDITIONS (MARK ALL THAT APPLY)

HEART DISEASE	Y / N	AIDS/HIV	Y / N	FEVER BLISTERS	Y / N	MIGRAINES	Y / N	SINUS TROUBLE	Y / N
HIGH BLOOD PRESSURE	Y / N	ARTHRITIS	Y / N	DIABETES TYPE I OR II	Y / N	NEUROLOGICAL ISSUES	Y / N	SLEEP DISORDERS	Y / N
LOW BLOOD PRESSURE	Y / N	OSTEOPOROSIS	Y / N	GASTROINTESTINAL DISEASE	Y / N	MENTAL HEALTH CONDITIONS	Y / N	SNORING/SLEEP APNEA	Y / N
ABNORMAL BLEEDING	Y / N	ULCERS	Y / N	REFLUX/HEARTBURN	Y / N	TUMORS/GROWTHS	Y / N	**OTHER:** _____	
CANCER/CHEMO	Y / N	BREATHING DISORDER	Y / N	ANEMIA	Y / N	JAW PAIN/GRINDING/CLENCHING	Y / N	_____	
HEPATITIS/LIVER DISEASE	Y / N	EPILEPSY/SEIZURES	Y / N	THYROID ISSUES	Y / N	BRUISE EASILY	Y / N	_____	
STROKE	Y / N	TUBERCULOSIS	Y / N	KIDNEY ISSUES	Y / N	NECK/BACK INJURY	Y / N		

DENTAL HISTORY

Why are you visiting today? _____

Who was your last dentist? _____

When was your last dental visit? _____

Have you used braces before? YES NO

Do your gums bleed? YES NO

Do you grind/clench? YES NO

Do you have dental fear? YES NO

Do you need to pre-medicate? YES NO

Do you need light sedation? YES NO

Do your teeth move? YES NO

Do you have dentures? YES NO

Do you have missing teeth? YES NO

Are you interested in esthetics? YES NO
If yes, please indicate:

Botox / Juvederm YES NO

Thread Lift YES NO

Buccal Fat Removal YES NO

Invisalign YES NO

ZOOM Whitening YES NO

COMMENTS

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SIGNATURE: X _____

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FINANCIAL / PRIVACY DISCLAIMERS

I will receive a written treatment plan with fees and projected insurance information if available. I must sign the plan in acknowledgement before booking treatment.

Payment is always due by the time services are rendered. Any bookings over $1000 or over 2 hours duration will require a 50% deposit upfront.

I am responsible for understanding my insurance coverage. The office will help me process claims but I will not hold them accountable for any claims rejected due to unforeseen plan limitations.

If I am an insurance patient I will be charged contracted fees. My payments will be due in full on date of service and reimbursements will be assigned/credited to me when refunded by insurers.

If I ask for insurance benefits to be assigned to the dental office, fees not covered by my insurer within 30 days will be due in full by me. **I will provide credit card information for such cases.**

In accordance with Florida State law, I may be **charged 1.5% per month surchange (18% per year) for delinquent accounts exceeding 30 days.**

In accordance with Florida State law, check payments **authorize collection fees when checks are dishonored**. Every check returned will have a **$25 fee if <$50, $30 fee if between $50-300 and $40 fee if >$300.**

I am required to give a **24 hour notice on changes to appointments.** The office may charge a **$1 penalization for every minute of lost appointment time** (e.g. $60 per hour, $120 every 2 hours).

Any appointment not confirmed within 24 hours prior to date of service may be subject to cancellation.

I will **provide mobile phone and/or email contact information** to the office to communicate electronically through its patient management system.

I authorize the dental office to transfer my records to another provider when referred for treatment. This does not obligate me to any doctor/patient relationship with any provider except by/of my own choosing.

I authorize release of records to hospital or health care plans, insurers or their representatives including xrays, medical history, or other information needed to review, investigate or evaluate claims for benefits.

If my insurance coverage is under agreement by my employer or similar entity, this authorization permits disclosure to them for purposes of utilizaiton review or financial audit.

I authorize the dental office to submit claims on my behalf. I authorize assignment of benefits otherwise payable to me, but not to exceed the providers actual charges for covered services.

I have read privacy notices and have the right to receive a copy of this authorization. I have the right to revoke this authorization too, in writing at any time.

I authorize the dental office to make routine calls to confirm my appointment. A message may be left with a responsible person or answering machine. Office staff may communicate in email or text when necessary.

Routine communications include but are not limited to text/email to confirm appointments, questions about potential treatment, questions after active treatment, and billing inquiries.

I authorize the following persons to have access to my health information: _____

CREDIT CARD AUTHORIZATION

I hereby authorize you to charge my credit card for any delinquent amounts due over 30 days post date of service:

CREDIT CARD NBR: _____ **CREDIT CARD TYPE:** ___ **VISA** ___ **AMEX** ___ **MASTERCARD** __ **CARECREDIT** ___ **DISCOVER**

EXPIRATION DATE: _____ **CCV (3 DIGITS IN BACK OR 4 IN FRONT FOR AMEX)** _____

SIGNATURE: X _____

I understand all the aforementioned disclaimers and accept them as noted. I am responsible for providing new credit card authorization should the card information on file no longer be valid for whatever reason including cards lost, stolen, or otherwise modified from the information noted above.

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SUPPLEMENTAL INFORMATION

(FOR CREDIT LINE OR MEDICAL LOAN APPLICANTS)

I am interested in applying for financing so that I can satisfy my dental dues in monthly installments versus all at once. I understand that the dental office offers financing through CareCredit, Proceed Finance, and Lending Point. I authorize the dental office to pre-qualify me for available funding offers from these third party organizations which will involve a soft-check of my credit. Without my explicit written approval, the dental office will not apply for funding or process credit applications that will entail a hard check of my credit score. For the purpose of prequalification, I am providing the following supplemental financial information:

[ALL APPLICANTS FOR FINANCING]

Do you own your place of residence or rent? OWN ____ RENT _____

What do you pay monthly (rent or mortgage)? MORTGAGE $_____ RENT $ _____

What is your **estimated monthly income** from all sources: $ _____

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SIGNATURE: X _____