Lake Lucerne
LIFESTYLE DENTISTRY

New Patient Information, Consents, Disclosures

To our patients: The information you provide us will let us render high quality oral healthcare. Please answer all questions as completely and accurately as possible and inform us as promptly if any pertinent information changes.

PATIENT INFORMATION

Today's Date: / /

Last Name:	First Name:	Middle Name:
Home Phone*:	Cell Phone/Texts*:	Work Phone*:
Email Address*:		Referred By:
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	Family Status: ☐ Single ☐ Married ☐ Child
Social Security Number:	Driver's License State of Issuance:	Expiration Date:
Emergency Contact Name:	Relationship:	Phone:

If you're completing this form for another person, provide your name and relationship to the patient. If executing this form as a patient's personal representative, you warrant that you have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason you no longer have such legal right and authority, you must immediately notify us in writing to info@lakelucernedentistry.com.

Name: ____ Relationship: _______________________

***IMPORTANT HIPAA NOTICE:** By signing this form, you give us permission to send appointment, billing or dental information by phone, text, voicemail, or email communication as needed. You acknowledge there is some level of risk that third parties might be able to read unencrypted emails. You are aware that you may withdraw this consent at any time, by calling 407-425-4901 or emailing info@lakelucernedentistry.com.

DENTAL HISTORY & SYMPTOMS

What is the reason or your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

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

Please mark only the boxes that apply to you.

- Is it hard to open your mouth? ☐
- Does it hurt to chew, bite, or swallow? ☐
- Do your gums bleed when you brush or floss? ☐
- Have you had periodontal treatment (e.g. scaling & root planing?..... ☐
- Have you had sores or growths in your mouth? ☐
- Do you clench or grind your teeth? ☐
- Does your jaw click, pop or hurt? ☐
- Do you have earaches or neck pains? ☐
- Does dental treatment make you nervous? ☐
- Have you experienced any sleep-related breathing disorders?.......... ☐
  ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

- Have you ever had a serious injury to your head/mouth? ☐
  If yes, please describe what happened and when it happened: _________
  ____
- Have you had problems with dental treatment before? ☐
  If yes, please describe what happened: _______________________________
  ____
- Have you had a reaction or problem with dental anesthesia? ☐
  If yes, describe what happened: ____________________________________
- Are you unhappy with your smile? ☐
  If yes, why? Please mark all that apply:
  ☐ The tooth color ☐ The tooth shape ☐ The tooth position ☐ Other

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please mark your answers to the following questions:	Yes	No	?
Are you taking **blood thinners** (Coumadin, Warfarin, Rivaroxaban (Xarelto®), Dabigatran (Pradaxa®), Clopidogrel (Plavix®), Heparin or Aspirin?).....	☐	☐	☐
If yes, what medication are you taking? ______________________________			
Are you taking any medication to treat **osteoporosis** or Paget's disease?	☐	☐	☐
Common drugs incl. Alendronate (Fosamax®), Risedronate (Actonel®), Ibandronate (Boniva®), Zolendronate (Reclast®) and Denosumab (Prolia®).			
If yes, what medication are you taking? __________________ How many years have you been taking it? __________			
Are you taking **IV medication** for bone pain, hypercalcemia or skeletal complications from Paget's disease, myeloma or metastatic cancer?	☐	☐	☐
Common drugs incl. Denosumab (Xgeva®), Pamidronate (Aredia®) or Zolendronate (Zometa®).			
If yes, what medication are you taking? __________________ How many years have you been taking it? __________			
Are you taking **hormonal replacements**?	☐	☐	☐
Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)?	☐	☐	☐
Do you use **vaping products**?	☐	☐	☐

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Please mark your answers to the following questions: Yes No ?

How many **alcoholic beverages** do you have per week? ________________

Do you use **controlled substances** (drugs) such as marijuana for either medicinal or recreational reasons? ☐ ☐ ☐

If yes, what substances? __________________ If yes, how often? ☐ Daily ☐ Several times weekly ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? ____

Do you take any other **prescriptions and/or over the counter medicine(s), vitamins, herbs, and/or supplements**? ☐ ☐ ☐

If yes, list them here and incl. how much and how often you use each one. ____

WOMEN ONLY: Are you:

Taking **birth control pills?** ☐ ☐ ☐

Pregnant? If yes, number of weeks: _________________ ☐ ☐ ☐

Nursing? If yes, number of weeks: __________________ ☐ ☐ ☐

ALLERGIES Please mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to: Yes No ?

Aspirin ☐ ☐ ☐
Barbiturates, Sedatives, or Sleeping Pills ☐ ☐ ☐
Codeine or Other narcotics ☐ ☐ ☐
Hay fever/seasonal allergies ☐ ☐ ☐
Iodine ☐ ☐ ☐
Latex (Rubber) ☐ ☐ ☐
Local anesthetics ☐ ☐ ☐
Metals ☐ ☐ ☐
Penicillin or other antibiotics ☐ ☐ ☐

Yes No ?

Sulfa drugs such as Sulfamethoxazole-Trimetrhoprim (Septra, Bactrim), Erythromycin-Sulfisoxazole, Sulfasalazine (Azulfidine), Erythromycin-Sulfisoxazole (Eryzole, Pediazole) Glyburide (Diabeta, Glynase PresTabs), Dapsone, Sumatriptan (Imitrex), Celecoxib (Celebrex), Hydrochorothiazide (Microzide) and Furosemide (Lasix) ☐ ☐ ☐

Other ☐ ☐ ☐

Please describe any "Yes" answers and include information about your experience. ______________________________________

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / What is your normal blood pressure (systolic, diastolic)? ___________

Doctor's Name: _________________________________ Contact Number: ____

Please mark your answers to the following questions: Yes No ?

Are you in good physical health? ☐ ☐ ☐
Are you currently being seen or treated by a physician for an ongoing condition? ☐ ☐ ☐
Has a physician or prior dentist recommended that you take **antibiotics** before having dental work done? ☐ ☐ ☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years? ☐ ☐ ☐
Have you had any (total or partial) **joint replacement** surgery (hip, knee, shoulder, elbow, finger, etc.)? ☐ ☐ ☐
Have you had a **heart valve replacement or heart surgery**? ☐ ☐ ☐
Have you had **organ or bone marrow/stem cell transplant**? ☐ ☐ ☐
Have you traveled internationally within the last 30 days ☐ ☐ ☐
Have you had a fever (100.4 F or above) in the last 72 hours? ☐ ☐ ☐

If you answered yes to any of the above, please explain: ____

MEDICAL HISTORY SPECIFIC Please mark your answers to the following questions:

Do you have, or have you been diagnosed with any of the following conditions?

Yes No ?

Heart (Cardiac) Health
Pacemaker/Defibrillator ☐ ☐ ☐
Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Congenital heart disease (CHD) ☐ ☐ ☐
Unrepaired, cyanotic CHD ☐ ☐ ☐
Repaired in last 6 months ☐ ☐ ☐
Repaired with residual defects ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Coronary artery disease ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐

Yes No ?

Cancer ☐ ☐ ☐
Type: _________________
Date of diagnosis: _______
Chemotherapy: _________
Radiation treatment _____

Blood (Circulatory) Health
Anemia ☐ ☐ ☐
Transfusion ☐ ☐ ☐
If yes, date: __________
Hemophilia ☐ ☐ ☐
High/low pressure ☐ ☐ ☐

Brain (Neurological)/Mental Health

Yes No ?

Digestive Health
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/Persistent heartburn (GERD) ☐ ☐ ☐
Stomach ulcers ☐ ☐ ☐

Eye (Vision) Health
Glaucoma ☐ ☐ ☐

Other
Arthritis ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes (Type I or II) ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Frequent infections ☐ ☐ ☐

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Condition	Yes	No	?
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental disorder	☐	☐	☐
Neuro disorder	☐	☐	☐
PTSD	☐	☐	☐
Brain injury	☐	☐	☐
Autoimmune Disease			
AIDS or HIV	☐	☐	☐
Lupus	☐	☐	☐
Type of infection: ________________			
Hepatitis, Jaundice, Liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection STI	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed? If so, explain:

MEDICAL SYMPTOMS/GENERAL Please mark your answers to the following questions:

In the past 30 days, have you:	Yes	No	?
Had chest pain or tightness	☐	☐	☐
Persistent cough (>3 weeks)	☐	☐	☐
Had exposure to tuberculosis	☐	☐	☐
Rapid/irregular heartbeat	☐	☐	☐
Had difficulty breathing	☐	☐	☐
Had fever >101.5F	☐	☐	☐
Had a change in vision	☐	☐	☐
Fainted inexplicably	☐	☐	☐
Vomiting, diarrhea, chills, night sweats, or bleeding?	☐	☐	☐
Had migraines or severe headaches	☐	☐	☐

IMPORTANT PATIENT SIGNATURES, ACKNOWLEDGEMENTS & CONSENTS

Cancellation, No-Show, Refund Policy (Must be Signed by All Patients)

All dental appointments must be re-confirmed 24 hours prior to avoid cancellation. Once confirmed, a credit card authorization of $1/per minute may be required ($60/hour, $120/2 hours, $240/4 hours, etc.). This fee will be refunded fully on the date of your visit unless you cancel or do not show. Changes to confirmed appointments are allowed 24 hours prior with no penalty. We require a 50% deposit for major procedures scheduled. Full refunds will be made for any procedures canceled minus cancellation fees (if any). If lab, planning or material costs were incurred by the practice in preparation for your procedure, you will be responsible for those costs as well. Bundled promotions cannot be unbundled. If you get preferential pricing for bundled services then cancel, you will be charged usual and customary rates for any services already rendered. Refund requests may take up to 10 business days to process. By signing below, I acknowledge that I understand and accept these policies.

Signature: ______________________________ Date: ______________________________

Photo/Video Release (Must be Signed by All Patients)

In connection with dental services rendered, I consent that photographs or videos may be taken of me for the explicit use of dental research, education, training, or science provided that in any such publication or use I shall not be personally recognizable, nor identified by name. I waive all rights to any claims for payment or royalties in connection with these photographs/videos.

Signature: ______________________________ Date: ______________________________

Privacy Statement for Patients (Must be Signed by All Patients)

Personal information for our purposes is that which is necessary to administer this dental practice, including all information that you have provided in forms, office visits, or during the normal course of communications with our dental staff. We are committed to protecting your personal information and have established training and security measures to properly manage and safeguard your data from loss, theft, and unauthorized access. Access to your data shall be on a "need to know" basis and will be limited to only that which is necessary for the recipient. Persons who are considered to be on a "need to know" basis may include other dentists, health care providers, insurance providers, or consultants for education purposes (e.g. ensuring best practices are being administered). Our office uses an automated email and text appointment reminder system which will send messages to you, with your consent. We will retain your personal information for the period necessary to continue providing your care, and for its related administration. We will destroy your information in a secure manner when it is no longer needed for compliance with federal regulations or statutes. You may at any time ask to see your records held by us and request amendments to the information. When requested, we will provide you access within a reasonable timeframe. By signing below, you acknowledge that you have read this Privacy Statement, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: ______________________________ Date: ______________________________

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New Patient Guide (Must be Signed by All Patients)

By signing below, I acknowledge that I received the New Patient Guide, I understand the policies within and I agree to abide by them.

Signature: ____ Date: ____________________________________

Insurance-Related Consents (Must be Signed by All Patients with Insurance)

To the extent permitted by law, I authorize payments of any dental benefit otherwise payable to me to be made to the dental practice instead. I understand that dental insurance may not cover all fees; and that estimated or preauthorized benefits are not guaranteed. I agree to pay any balance not paid by insurance within 60 days after the date of service. Per Florida Statutes, a service charge of 1.5% per month (18% per annum) may be charged on balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. If collection fees are incurred by the dental office relating to any unpaid or delinquent balance I will be responsible for those fees, whether or not a suit is filed. The dental office may terminate or deny any treatment if my patient account is delinquent.

Signature: ____ Date: ____________________________________

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: ____

Relationship to Patient: _______________________________________

I authorize the following information to be released:

- ☐ All treatment information
- ☐ X-rays, Photos, and other diagnostic records
- ☐ Financial information including ledger, receipts, etc.
- ☐ All of the above

Signature: ____ Date: ____________________________________

I certify that I have read and understand the information contained in this form. I attest that questions have been answered to the best of my knowledge. I give my consent to the dental office and its staff to perform an exam and diagnose my condition. I also authorize the dental office to administer such medications and perform such therapeutic procedures as may be necessary for proper dental care. I know that dentistry is not an exact science and that no guarantee is or can be given by the dental office or any person employed or contracted there regarding the results that may be obtained. I understand I must comply with all specified appointments, procedures, and continuing care and that failure to do so may adversely affect my treatment. Extra treatment (or retreatment) necessary due to my non-compliance will likely involve additional fees. The dental office does not exercise control over the individual professional services of any of its treating dentists or hygienists; therefore, I know I shall solely hold the treating dentist responsible for any treatment performed. I agree to hold Lake Lucerne Lifestyle Dentistry (aka Gustavo De Oliveira, DMD, PA) harmless. This consent will be in effect until cancelled, or until care at the dental office is terminated.

Signature of Patient/Legal Guardian: ______________________________ Date: ____________________________________

FOR COMPLETION BY DENTIST

Comments:

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: ____ **Date:** ____________________________________