Lake Lucerne
LIFESTYLE DENTISTRY

NEW PATIENT FORM. WELCOME TO LAKE LUCERNE LIFESTYLE DENTISTRY. TELL US ABOUT YOURSELF!

YOUR PERSONAL INFORMATION

(This information is mandatory by law for our files and will be considered strictly confidential)

SALUTATION	*Mr, Mrs, Miss, Dr*	**PATIENT NAME***	*First Name, Middle Name, Last Name*	**TODAY'S DATE***	*MM/DD/YYYY*
ADDRESS*	*Bldg #, Street, Apt #*	**CITY/STATE***		**ZIP CODE***	
GENDER	*Male, Female*	**REFERRAL TYPE***	*Friend/Family, Doctor, Suppler, Website, Insurance, Organization, Other*	**REFERRER***	*Specify who referred you*
WORK EMAIL*	*(indicate N/A if it does not apply)*	**PERSONAL EMAIL***		**EMAIL YOU PREFER WE USE**	*Work, Personal*
WORK TEL*	*(indicate N/A if it does not apply)*	**PERSONAL TEL***		**PHONE YOU PREFER WE USE**	*Work, Personal*
STATUS*	*Married, Single, Divorced, Widowed, Minor < 18*	**DATE OF BIRTH***	*MM/DD/YYYY*	**SOC SECURITY NUMBER***	*###-##-####*
ID TYPE*	*Driver's License, Non Driver ID, Passport*	**OFFICIAL ID#***		**IS A COPY OF ID ON FILE?**	*Yes, No (Internal Use)*

OTHER IMPORTANT CONTACTS

(This information is crucial, for emergency purposes, please complete all fields)

YOUR EMPLOYER*	*Who you work for (indicate N/A if it does not apply)*	**EMPL ADDRESS***	*Where you work (indicate N/A if it does not apply)*	**EMPLOYER TEL***	*How to reach your employer (or N/A)*
YOUR PHYSICIAN*	*Who is your doctor (full name)*	**PHYS ADDRESS***	*Your Primary Doctor's Address*	**PHYSICIAN TEL***	*How to reach your doctor*
YOUR PHARMACY*	*Which pharmacy is nearest to you*	**PHARMA ADDRESS***	*Your pharmacy address*	**PHARMA TEL***	*Your pharmacy telephone*
EMERGENCY CONTACT*	*Name of person we can call in an emergency*	**RELATIONSHIP***	*Spouse, Relative, Friend, Other*	**EMERGENCY TEL***	*Where to call in an emergency*

DENTAL INSURANCE

☐ Check here to skip this section if your form of payment is not Insurance

(All insurance patients must provide a copy of their card for verification purposes)

INSURANCE PROVIDER*	*Aetna, Guardian, Delta Dental, United, Cigna*	**GROUP #***	*Located in front of card*	**SUBSCRIBER ID #***	*Located in front of card*
INSURANCE ADDRESS*	*Where to send claims to (back of card)*	**PAYOR #***	*Located in back of card*	*(If there is a secondary insurance indicate in comments below)*	
INSURANCE TEL*	*Physician's Number (back of card)*	**INSUREDS NAME***	*Name of Primary Subscriber*	**RELATION TO PATIENT***	*Self, Spouse, Child, Parent, Other*
INSUREDS DOB*	*Subscriber date of birth MM/DD/YYYY*	**INSUREDS SSN***	*Social Security Number of Subscriber*	**INSUREDS EMPLOYER***	*Employer of Subscriber*

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COMMENTS

Important Notice About Your Insurance

If you have insurance, Lake Lucerne Lifestyle Dentistry will help you determine the coverage you have avaliable. We ask that you assign your insurance benefits to us. ***Professional care is provided to you, our patient, and not to an insurance company.*** *Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor.* ***Insurance balances 60 days and over are due in full from the patient.***

ASSIGNMENT & RELEASE *(The signature of the party responsible for payment of services rendered to the patient is required here)*

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I undertand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic 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 payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor. In connection with dental services I am receiving, I consent that photographs, audio, and or video recording may be taken of me for the explicit use of dental research, education, training, or science; provided, however that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs/video tape regardless of whether such use is commercial, institutional, or private sponsorship and irrespective of whether any fee or charge is received.

SIGNATURE: X **Signature Date:**

MM/DD/YYYY

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MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

(These questions are necessary for proper care. They assure that treatment takes into consideration your past and present health).

ARE YOU IN GOOD HEALTH?*	YES / NO	ARE YOU TAKING MEDICATIONS NOW?*	YES / NO	*use the space in the comments box if needed	
DATE OF LAST PHYSICAL EXAM*		*IF YES, WHAT MEDICATION(S)?*			
ARE YOU UNDER MEDICAL CARE?*	YES / NO	*WHAT DOSAGE?*			
IF YES, WHAT FOR?		DO YOU HAVE ANY KNOWN ALLERGIES?*	YES / NO		
HAVE YOU HAD A SERIOUS ILLNESS?	YES / NO	*LOCAL ANESTHETICS*	YES / NO	*ASPIRIN*	YES / NO
IF YES, WHAT WAS IT?		*PENICILLIN OR OTHER ANTIBIOTICS*	YES / NO	*SULFA DRUGS*	YES / NO
HAVE YOU BEEN HOSPITALIZED?*	YES / NO	*BARBITURATES, SEDATIVES, SLEEPING PILLS*	YES / NO	*CODEINE OR OTHER NARCOTICS*	YES / NO
IF YES, WHAT FOR?		*IODINE*	YES / NO	*LATEX (RUBBER)*	YES / NO
DO YOU SMOKE?*	YES / NO	*OTHER*		*METALS*	YES / NO
IF YES, HOW MUCH/OFTEN?		***-----FOR WOMEN ONLY-----***			
DO YOU DRINK ALCOHOL?*	YES / NO	ARE YOU PREGNANT OR MAY BE PREGNANT?*	YES / NO	ARE YOU NURSING?*	YES / NO
IF YES, HOW MUCH IN LAST 24 HRS		*IF YES, HOW MANY WEEKS?*		TAKING BIRTH CONTROL?*	YES / NO

Please indicate whether you have or have had any of the following conditions (Circle One)

ARTIFICIAL HEART VALVE	YES / NO	AIDS OR HIV INFECTION	YES / NO	HEPATITIS/JAUNDICE/LIVER DISEASE	YES / NO	TUMORS OR GROWTHS	YES / NO
INFECTIVE ENDOCARDITIS	YES / NO	ARTHRITIS	YES / NO	EPILEPSY	YES / NO	PAIN IN JAW JOINTS	YES / NO
HEART TRANSPLANT	YES / NO	AUTOIMMUNE DISEASE	YES / NO	SEIZURES	YES / NO	CHEST PAINS	YES / NO
CONGENITAL HEART DISEASE	YES / NO	HEMOPHELIA	YES / NO	NEUROLOGICAL DISORDERS	YES / NO	TEETH GRINDING/CLENCHING	YES / NO
CARDIOVASCULAR DISEASE	YES / NO	OSTEOPOROSIS	YES / NO	MENTAL HEALTH CONDITIONS	YES / NO	BREATHING DIFFICULTIES	YES / NO
ANGINA	YES / NO	MIGRAINES	YES / NO	RECURRENT INFECTIONS	YES / NO	ADD/ADHD	YES / NO
ARTERIOSCLEROSIS	YES / NO	COLD SORES/FEVER BLISTERS	YES / NO	KIDNEY PROBLEMS	YES / NO	BRUISE EASILY	YES / NO
CONGESTIVE HEART FAILURE	YES / NO	ASTHMA	YES / NO	THYROID PROBLEMS	YES / NO	NECK, BACK INJURY	YES / NO
DAMAGED HEART VALVES	YES / NO	BRONCHITIS	YES / NO	STROKE	YES / NO	SINUS TROUBLE	YES / NO
HEART ATTACK	YES / NO	EMPHYSEMA	YES / NO	GLAUCOMA	YES / NO	SLEEP DISORDERS	YES / NO
HEART MURMUR	YES / NO	CANCER/CHEMO TREATMENT	YES / NO	ANEMIA	YES / NO	SNORING/SLEEP APNEA	YES / NO
OTHER HEART DEFECTS	YES / NO	DIABETES TYPE I OR II	YES / NO	BLOOD TRANSFUSION	YES / NO	OTHER (INDICATE BELOW)	YES / NO
LOW BLOOD PRESSURE	YES / NO	EATING DISORDER	YES / NO	SEXUALLY TRANSMITED DISEASE	YES / NO		
HIGH BLOOD PRESSURE	YES / NO	GASTROINTESTINAL DISEASE	YES / NO	RHEUMATIC FEVER	YES / NO		
MITRAL VALVE PROLAPSE	YES / NO	REFLUX/HEARTBURN	YES / NO	ABNORMAL BLEEDING	YES / NO		
PACEMAKER	YES / NO	ULCERS	YES / NO	TUBERCULOSIS	YES / NO		

COMMENTS

AUTHORIZATION

(Signature of patient or parent/guardian is required here)

The information I have provided on this form is accurate and complete to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in the above information. I will not hold the dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

SIGNATURE: X _____ **Signature Date:** _____ MM/DD/YYYY

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DENTAL QUESTIONNAIRE

DENTAL HISTORY

(These questions are necessary for proper care. They assure that treatment takes into consideration your past and present health).

REASON FOR TODAY'S VISIT*		HOW DO YOU DESCRIBE YOUR DENTAL HEALTH*		WHEN WAS YOUR LAST DENTAL VISIT*	
WHO WAS YOUR PREVIOUS DENTIST		HAVE YOU HAD A POOR DENTAL EXPERIENCE?*	YES / NO	WHEN WAS YOUR LAST CLEANING*	
WHY DID YOU LEAVE		DO YOU NEED ANTIBIOTICS BEFORE TREATMENT*	YES / NO	WHEN WERE YOUR LAST XRAYS TAKEN*	
FLOSSING FREQUENCY (X WKLY)*		HAVE YOU HAD GUM TREATMENT*	YES / NO	HAVE YOU HAD BRACES BEFORE?*	YES / NO
BRUSHING FREQUENCY (X DAY)*		*IF YES, WHEN*		*IF YES, FOR HOW LONG?*	
TYPE OF BRUSH PREFERRED		ANY ISSUES WITH LOCAL ANESTHETICS?*	YES / NO	DO YOUR GUMS BLEED WHEN YOU BRUSH*	YES / NO
DO YOUR TEETH MOVE?*	YES / NO	DO YOU HAVE ANY DENTAL ANXIETY?*	YES / NO	DO YOU HAVE HOT/COLD SENSITIVITY*	YES / NO
DO YOU HAVE BAD BREATH?*	YES / NO	*IF YES, DESCRIBE HOW MUCH*		DO YOU HAVE MISSING TEETH*	YES / NO
DO YOU HAVE DENTURES?*	YES / NO	DO YOU NEED SEDATION PRIOR TO TREATMENT*	YES / NO	DO YOU GRIND YOUR TEETH*	YES / NO
IF YES, HOW OLD ARE THEY		*IF YES, WHAT APPROACH DO YOU PREFER*		IS YOUR MOUTH OFTEN DRY*	YES / NO
DO YOU LIKE THEM?	YES / NO	DO YOU CLICK, POP, HAVE PAIN IN JAW?*	YES / NO	IS YOUR WATER AT HOME FILTERED	YES / NO
DO YOU LIKE YOUR SMILE?*	YES / NO	WOULD YOU CONSIDER BOTOX/FILLERS?	YES / NO	HOW OFTEN DO YOU DRINK BOTTLED WATER	
IF NO, WHY NOT		*IF YES, DESCRIBE WHERE (USE SPACE BELOW)*		DOES SAME-DAY DENTISTRY INTEREST YOU	YES / NO
DOES SPA DENTISTRY INTEREST YOU	YES / NO	DOES DENTAL AROMATHERAPY INTEREST YOU	YES / NO		

COMMENTS

AUTHORIZATION

(Signature of patient or parent/guardian is required here)

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SIGNATURE: X _____ **Signature Date:** _____ MM/DD/YYYY

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FINANCIAL POLICIES

At Lake Lucerne Lifestyle Dentistry, we are committed to providing the finest care available to our patients. To achieve this, we have made significant investments in best-in-class technology that will shorten the duration of treatments, often resulting in same-day resolutions. For patients with high anxiety, our scientifically advanced equipment ensures the greatest amount of comfort, which means little to no bleeding or pain. To ensure you are confident about the diagnoses we give and the treatment plans we recommend, we go the extra mile to illustrate any conditions identified on-screen, and provide thorough explanations of how we intend to address them. Once you are satisfied with the diagnosis and plan forward, we offer flexible payment options to ensure finances are never a barrier to receiving proper and timely care. We know you have a choice, and we appreciate the trust you have invested in us. Below are important practices we have put in place to ensure timely payment for services rendered.

1. TRANSPARENT TREATMENT PLANS AND COST ESTIMATES

You will receive a clear and comprehensive treatment plan once we assess your overall oral health. It will be accompanied by a detailed estimate of the associated costs, including estimated insurance benefits if applicable. To ensure utmost transparency, we ask patients to accept treatment plans in writing- and specify the forms of payment upfront.

2. PAYMENT POLICY

Payment is due no later than when services are rendered. Acceptable forms of payment include cash, most major credit cards, checks or money orders, CareCredit, and assigned insurance benefits. For comprehensive plans over $5,000 requiring multiple office visits, we will require a minimum deposit of 50% upfront, with the remainder due in alignment to the delivery of services. ***For pre-paid treatment plans over $5,000 or made in cash, money order, or check, we offer a courtesy discount of 5% (or 3% for pre-payments made by credit card).***

3. DENTAL INSURANCE

All insurance coverage MUST BE verified before treatment begins. Patients who subscribe to insurance providers we participate with will be billed in accordance to the terms of our agreement with each insurer. Insurance is not a guarantee of payment and often, it will not cover all costs involved with your treatment. We will assist in confirming coverage upfront and we will file your claim as a courtesy to you however estimates provided by us should be considered guidelines until the final insurance payment is received and your account is reconciled. **You are ultimately responsible for any dues that insurance does not cover.**

4. SERVICE CHARGES / PENALTIES

In accordance to Florida State Law, **a service charge of 1.5% per month (18% per year) will be applied on all delinquent accounts exceeding 30 days.** No shows or last minute cancellations leave your caregivers with empty treatment chairs that other patients could have utilized had you informed us in a timely manner. For this reason we require a 24 hour notice on any changes to scheduled appointments and **we reserve the right to charge $1 for each minute of lost appointment time otherwise.**

5. CHECK COLLECTION

Payment by check authorizes the initiation of a debit entry to your checking account at your bank for the amount on the check PLUS an additional amount for applicable collection fees, if the check is dishonored. **Florida law designates that the following fees will be due for every check returned: $25 for checks under $50; $30 for checks between $50-300; $40 for checks over $300.**

Financial Authorization

(This is your authorization to settle dues, including balances not covered by Insurance. Copy of credit card is required.)

Credit Card Type _____ *Visa, Mastercard, American Express*

Credit Card # _____

Exp. Date ___/___/___ MM/DD/YYYY

CCV (3 Digits) _____ *Back of card*

I hereby acknowledge and accept the above policies and authorize the use of the referenced credit card to settle any unpaid dues.

SIGNATURE: X _____

Signature Date: _____ MM / DD / YYYY

☐ **Check here if you acknowledge these financial obligations but will settle in cash, check or money order.**

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HIPAA PRIVACY AUTHORIZATION

This represents your authorization for the disclosure of protected health information as required by Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164.

I. Transfer records to other providers

I authorize Dr. De Oliveira and staff to perform all procedures that are discussed and mutually agreed to in the course of treatment upon myself, the patient. I authorize Dr. De Oliveira and staff to transfer my records to another healthcare provider in the event of a referral for treatment. This authorization in no way obligates me to continue a doctor/patient relationship with any healthcare provider except by and of my own choosing.

II. Release to hospitals

I authorize Dr. De Oliveira to release to hospital or health care service plans, insurance companies, self-insured or their representatives any and all information and records (including xrays) about my medical history, or about services rendered or treatment given to me that is needed to review, investigate, or evaluate any claim for benefits. If my coverage is under group master agreement held by my employeer, an association, trust fund, union, or similar entity, their authorization also permits disclosure to them for purposes of utilization review or financial audit.

III. Submit claims to dental insurance companies

I authorize Dr. De Oliveira to submit claims for payment for services to my dental insurance company on my behalf and in my name and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. If the benefits are paid in full at the time of service, benefits will be assigned to me. I understand that I am financially responsible for any charges not covered by group insurance benefits.

IV. Privacy Practices

I have read a copy of this office's Notice of Privacy Practices. I know that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization, in writing at any time.

V. Routine Communications

I authorize this office to make routine calls to confirm my appointment and understand a message may be left with a responsible person or answering machine. I further agree that Dr. De Oliveira and/or staff members may communicate with me in email and text messages when necessary. This includes but is not limited to: text/email to confirm my appointments, questions regarding potential treatment, questions following active treatment.

VI. Other Parties who can receive you information

I authorize the persons below to have access to my health information: (This may include your spouse, children, parents, or caregivers who can access your patient records)

_____ **NAME** _____ **RELATIONSHIP**

_____ **NAME** _____ **RELATIONSHIP**

_____ **NAME** _____ **RELATIONSHIP**

I hereby acknowledge and accept the above policies and authorize the use of the referenced credit card to settle any unpaid dues.

SIGNATURE: X _____ **Signature Date:** _____

MM / DD / YYYY