Welcome to Lakeshore FAMILY Dental CARE

Child's Last Name: _____ First Name: _____ M.I. ___ Preferred Name:_____
Home Address: _____ City: _____ State: _____ Zip_____
Home Phone: (_____) _____ Who referred you to our office? _____
DOB: _____/_____/_____ Age: _____ SS#:_____-_____-_____ □ Male □ Female

Parent/Guardian Name:_____ Relation _____ E-mail_____
Home Address: _____ City: _____ State: _____ Zip_____
Home Phone: (___) _____ Work Phone: (___) _____ Ext____Cell Phone: (___) _____
Guardian's SS#:_____ DOB: ____/____/____ Drivers License #: _____
Employer: _____How Long? _____ Occupation: _____
Employer's Address: _____City: _____ State:_____ Zip_____

Parent/Guardian Name:_____ Relation _____ E-mail_____
Home Address: _____ City: _____ State: _____ Zip_____
Home Phone: (___) _____ Work Phone: (___) _____ Ext____Cell Phone: (___) _____
Guardian's SS#:_____ DOB: ____/____/____ Drivers License #: _____
Employer: _____How Long? _____ Occupation: _____
Employer's Address: _____City: _____ State:_____ Zip_____

Primary Dental Insurance Coverage

Subscriber Name: _____ Relation_____
DOB: ___/___/___ SS#:_____ ID# _____ Group # (Plan, Local or Policy #): _____
Insured's Employer: _____
Insurance Company Name: _____ Phone: (_____) _____

Secondary Dental Insurance Coverage

Subscriber Name: _____ Relation_____
DOB: ___/___/___ SS#:_____ ID# _____ Group # (Plan, Local or Policy #): _____
Insured's Employer: _____
Insurance Company Name: _____ Phone: (_____) _____

Child's Medical History

Please list <u>all</u> medications your child is currently taking _____
_____

Does your child have or ever had any of the following diseases, medical conditions, or procedures?

□ Heart Murmur
□ Rheumatic Fever
□ Artificial Heart Valves
□ Congenital Heart Defect
□ Scarlet Fever
□ Surgeries/Operations
□ Cancer/Tumors
□ Chemotherapy
□ Jaw Problems

□ Hearing Problems
□ Tonsillitis
□ Respiratory Problems
□ Asthma/Difficulty Breathing
□ Blood Transfusion
□ Leukemia/Anemia
□ Diabetes/Hypoglycemia
□ Hemophilia

□ Abnormal Bleeding
□ Cleft Lip/Palate
□ Birth Defects
□ High Blood Pressure
□ Low Blood Pressure
□ Hepatitis
□ Artificial Bones/Joints
□ Liver/Kidney/Organ Problems

□ HIV+/AIDS/ARC
□ Tuberculosis TB
□ Psychiatric Problems
□ Hyper Active/ADD
□ Fainting
□ Seizures/Epilepsy
□ Cerebral Palsy
□ Pregnancy

Please list any surgeries or medical conditions your child has or ever had: _____
_____

Is your child <u>allergic</u> to any of the following? □ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Sulfa □ Dental anesthetics
□ Foods: _____ □ Others: _____
Has your child ever taken Ritalin? □ No □ Yes/How long? _____

Signature _____ Date _____/_____/_____
□ Parent or Guardian

Truth In Lending

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time the services are rendered.

Patients who carry dental insurance understand that your insurance is a contract between you and your insurance company and that you are personally responsible for payment of all dental services. We bill your dental insurance as a courtesy; however, you are responsible for any amount not paid by your insurance company. We will estimate your copay for each appointment and payment is expected at time of treatment if a copayment applies. This office will submit the patient's insurance forms and assist in making collections from insurance companies and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can be extended for a period of three months from the date of consultation. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a waiver of any further term or condition and further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

I acknowledge that I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
(signature)

_____
(printed name)

Hipaa

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
-Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly -Obtain payment from designated third-party payers.
-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.
I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link {https://yapi.me/shared/hipaa2013.pdf} or in office in print form).
I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Lakeshore Family Dental Care has the right to change its Notice of Privacy Practices from time to time and that I may contact Lakeshore Family Dental Care at any time to obtain a current copy of the Notices of Privacy Practices.
I understand that I may request in writing that Lakeshore Family Dental Care restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Lakeshore Family Dental Care is not required to agree to my requested restrictions, but if Lakeshore Family Dental Care does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Lakeshore Family Dental Care has taken action relying on this consent.

Please list any other parties who can have access to patient's health information.

Name:
_____

Relationship:
_____

Name:
_____

Relationship:
_____

Name:
_____

Relationship:
_____

Name:
_____

Relationship:
_____

504 E. Colby St. | Whitehall, Michigan 49461
Phone: (231) 894-8814 | Fax: (231) 893-6505
LakeshoreFamilyDentalCare504@gmail.com

Records Release Request

Patient name: _____ Date of Birth: _____

Previous Dental Office: _____

Name(s) of family members to transfer: _____

_____

I hereby give you permission to release any and all of my dental records to:

_____
(New dental office/Dr.'s name)

_____
(New dental office address)

_____
(New dental office email)

Patient/Guardian Signature: _____ Date: _____