LOVELL DENTAL

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE, PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN.

Patient Information:

Date: _____ Name: _____

Phone: _____ Sex: M____ F____

Birthdate: _____ Social Security # _____

Child____ Single____ Married____ Widowed____ Separated____ Divorced____

Address: _____ City: _____ State: ____ Zip: _____

Employed by: _____ Occupation: _____

If student, School name: _____

Has any other family member been here before? _____ Name: _____

Relationship: _____

Insurance Name: _____ Telephone #_____

Policy Holder: _____ Policy Holder DOB: _____

ID#: _____ Group#: _____

Address: _____

In case of emergency who should be notified? _____

Phone: _____ Relationship: _____

If patient is a child, please fill out next part:

Responsible Person: _____ Relationship to Patient: _____

Birthdate: _____ Social Security#: _____ Sex: M___ F___

Phone #_____

Address: _____ City: _____ State: _____ Zip: _____

Employed by: _____ Occupation: _____

Dental History:

Reason for today's visit: _____

Date of last dental visit: _____ Dentist Name: _____

Check if you have problems with any of the following:

Bad breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth	Sensitivity to sweets
Food collection between teeth	Sores or growths in your mouth	Sensitivity to cold
Broken fillings	Clicking or popping jaw	Sensitivity when biting
Please list other problems:		

How often do you floss? _____How often do you brush? _____

Medical History:

Physician's Name: _____Physicians phone number: _____

Have you had any serious illnesses or operations? If yes, describe: _____

List medications you are currently taking: _____

_____

List any allergies: _____

_____

(Women) Are you pregnant? __Yes __No Nursing? __Yes __No Taking birth control pills? __Yes __No

Check if you have or have had any of the following:

Anemia	Cortisone Treatments	Hepatitis	Shortness of Breath
Arthritis	Cough, Persistent	High Blood pressure	Skin Rash
Artificial heart Valves	Diabetes	HIV/AIDS	Stroke
Asthma	Epilepsy	Jaw Pain	Swelling
Back Problems	Fainting	Liver Disease	Thyroid Problems
Blood Disease	Glaucoma	Kidney Disease	Tobacco Habit
Cancer	Headaches	Pacemaker	Tonsillitis
Chemotherapy	Heart Murmur	Radiation Treatment	Tuberculosis
Circulatory Problems	Heart Problems	Respiratory Disease	Ulcer
Circulatory Problems	Hemophilia	Rheumatic Fever	Venereal Disease
Please list other problems:			

Signature_____ Date_____

(If patient is a child, parent signature is needed)

OFFICE POLICIES

- $50 fee will be assessed on missed appointments with less than 24-hour notice, after 3 missed appointments without 24-hour notice we will no longer be able to schedule an appointment for you; as our time is very important as well as the time of our committed patients.

- I understand and acknowledge that I am financially responsible for the services provided for myself or any dependents, regardless of insurance coverage on the day services are rendered.

- All fees are due and payable at the time of your appointment. For your convenience, we accept cash, check, MasterCard, Visa, Discover and Care Credit. 5% discount is given on cash (only) payments.

- As a courtesy we allow you to pay your deductible and/or estimated co-payment at the time of treatment.

- I understand that my insurance policy is a contract between my insurance provider and myself, not between the insurance company and Lovell Dental.

- I also understand that insurance policies vary greatly from one policy to the next and that Dr. Anderson and his staff are not responsible for knowing all the details of my policy.

- Lovell Dental has no control over payments received by insurance companies.

- Any balance left unpaid by your insurance company 60 days after service is due in full by you.

- We reserve the right to assess fees for: Returned Checks ($35)

- Any balance over 90 days will be sent to collection and will inquire additional charges and fees

- Balances older than 60 days without monthly payment are subject to interest charges of 24% APR, this fee is not refundable.

- Lovell Dental is not prohibited from providing services that are not covered by insurance. If a procedure is not a covered benefit you will be made aware before treatment of what the cost will be. Lovell Dental will charge their usual fee for noncovered services in accordance with any state or federal law.

- I give my CONSENT to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending Dentist or by his supervised staff for diagnostic purposes or dental treatment.

The undersigned has read and accepts the above, and agrees to abide by all terms and conditions as stated.

Patient Signature: _____

Date: _____ **(If patient is a child, parent signature is needed)**

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to request and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to report of disclosures of your information.
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will ensure that your information remains private.

Please list all telephone numbers where we may contact you:

1._____ 2._____ 3._____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g., SPOUSE, PARENTS, GRANDPARENTS, ETC...) YOU AUTHORIZE TO RELEASE YOUR HEALTH INFORMATION TO.

Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have reviewed Lovell Dental's Notice of Privacy Practice. I further understand that the practice will offer me updates to this Notice of Privacy Practice. Should it be amended, modified or changed in any way I will receive a copy.

Signature: _____ Printed Name of Patient _____