LOVELL DENTAL

PATIENT INFORMATION

Date: ____________

Name: (first) ____________ (last) ________________ I Prefer to be called: ____________ ☐ Male ☐ Female

Address: ______________________ City: ____________ State: _____ Zip: ________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________ TEXT: ☐ Y ☐ N

Employer: ______________________ School: ______________________

Date of Birth: ____________ SS#: ____________ Driver's License #: ____________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse or Guardian/Parent's Name: ______________________ Phone: ____________

Person to contact in case of emergency: ______________________ Phone: ____________

RESPONSIBLE PARTY

Same as above: ☐

Name: ______________________ Relationship to Patient: ____________

Address: ______________________

City: ____________ State: _____ Zip: ________ Phone: ____________

Employer: ____________ Work Phone: ____________ SS#: ____________

INSURANCE INFORMATION

Name of Insured: ______________________ Date of Birth: ____________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

SS#: ____________ Name of Employer: ____________ Work Phone: ____________

Address of Employer: ____________ City: ____________ State: _____ Zip: ________

Insurance Company: ____________ Grp #: ____________ Subscriber ID#: ____________

Ins Co Address: ______________________ Ins Co Phone: ____________

------ DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------

Name of Insured: ______________________ Date of Birth: ____________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

SS#: ____________ Name of Employer: ____________ Work Phone: ____________

Address of Employer: ____________ City: ____________ State: _____ Zip: ________

Insurance Company: ____________ Grp #: ____________ Subscriber ID#: ____________

Ins Co Address: ______________________ Ins Co Phone: ____________

Thank you for choosing us!

LOVELL DENTAL

Patient Name: (first)______________ (last)______________________ **Date of Birth:** ____________

DENTAL HISTORY

Previous Dentist: ______________________________ **Date of last dental visit:** ____________________

Do you like the way your teeth look? ☐ **Yes** ☐ **No**

Are you happy with the color of your teeth? ☐ **Yes** ☐ **No**

Would you like your teeth to be whiter? ☐ **Yes** ☐ **No**

Would you like your teeth to be straighter? ☐ **Yes** ☐ **No**

Do you have spaces between your teeth that you would like closed? ☐ **Yes** ☐ **No** If so, Upper_____ Lower_____ Both_____

Would you like your teeth to be longer? ☐ **Yes** ☐ **No**

Do you like the shape of your teeth? ☐ **Yes** ☐ **No**

Do you have missing teeth that you would like to be replaced? ☐ **Yes** ☐ **No**

Do you have old silver fillings that you would like to be replaced with white colored fillings? ☐ **Yes** ☐ **No**

If you could change anything about your smile, what would you change? ______________________________

HEALTH HISTORY

Check if you have or had any of the following:

___AIDS	___Diabetes	___Liver Disease	___Sinus Trouble
___Anemia	___Epilepsy, Seizures	___Lung Disease	___Skin Rash
___Arthritis	___Fainting, Dizziness	___Major Surgery, Type:	___Stroke
___Artificial Heart Valve	___Glaucoma	____________________	___Swelling of Feet or Ankles
___Artificial Joints	___Headaches	___Mitral Valve Prolapse	___Taking Fen-Phen or
___Asthma	___Heart Attack	___Nervous Problems	___Thyroid Problems
___Back Problems	___Heart Murmur	___Pacemaker	___Tobacco Habit, Type:
___Cancer, Tumor Malignancy	___Hepatitis, Type____	___Pain in Jaw Joint	____________________
___Chemical Dependency	___Herpes	___Prolonged Bleeding Disorder	How much?__________
___Chemotherapy	___High Blood Pressure	___Psychiatric Care	___Tonsillitis
___Circulatory Problems	___HIV Positive	___Radiation Treatment	___Tuberculosis
___Cortisone Treatments	___Hospitalization	___Respiratory Disease	___Ulcer
___Cough up blood	___Immune Disorder	___Rheumatic Fever	___Venereal Disease
___Congenital Heart Disorder	___Jaundice	___Scarlet Fever	___Are you Pregnant?
___Cough, Persistent	___Kidney Disease	___Shortness of breath	Due Date: __________

___Other: ____

Medications

List medications you are currently taking:
(Include oral contraceptives and alternative medicines)

__________ __________ __________
__________ __________ __________
__________ __________ __________

Allergies

___Aspirin	___Local Anesthetic
___Barbiturates	___Penicillin
___Codeine	___Sulfa
___Latex	
___Other: ______________	

Have you taken Bisphosphate for bone density, such as:
Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Reclast, Zometa? _______

Do you have cancer? _______
If so have you been treated? _______

☐ By checking this box and signing below, I agree that the above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of Lovell Dental responsible for any errors or omissions that I may have made in the completion of this form.

Signature **Date:**

LOVELL DENTAL

Patient Name: (first)____________ (last)__________________ **Date of Birth** ___________

FINANCIAL POLICY

Payment for services is due at the time service is rendered unless financial manager has approved payment arrangements in advance. We accept **CASH, CHECKS, CARE CREDIT, MASTERCARD, VISA,** and **DISCOVER.**

As a courtesy to our insured patients we will file your insurance claim for you and accept the assignment of benefits, however, any co-payment and deductible is due at the time of service.

- Your insurance is a contract between you and your employer, and the insurance company. We will do our best to inform you of your contract benefits but it is ultimately the patient's responsibility to be aware of the particular contract provisions of restrictions. We will not be liable for services not covered in an individual's contract. In providing proper dental care, we will assume all patients' desire to complete their dental treatment needs in a timely fashion. It is the patients' responsibility to monitor their insurance maximum, and inform us if they do not wish to exceed the limit. Patients should be aware of dental treatment provided in another office will affect their insurance maximum, and our office would be unaware of such treatment performed.
- Some insurance companies downgrade posterior composites to amalgam prices. If this is the case, you are responsible for the difference in pricing.
- Balances older than **30** days are subject to interest charges of **18% APR** (regardless of any insurance claim status). Any refund due to you will be processed monthly. Requested patient records will be released after account balance is cleared of any balance due.
- Any balance over 90 days, of patient responsibility, will be subject to a one time fee of $20.
- Returned checks are subject to a $25 collection fee.
- Broken appointments and appointments cancelled without a **24-hour** notice are subject to a **$50** fee.
- Your name and address are never sold to a third party.

TREATMENT PLANS AND INSURANCE ESTIMATES

Lovell Dental provides treatment plan and financial estimate at check out. I understand that this is an estimate, and that my treatment may change during the procedure due to the extent of the decay, patient behavior, or other unexpected situations.

Parent/Guardian (if patient is a minor) **Signature** **Date:**

NOTICE OF PRIVACY POLICY

The information provided below illustrates the manner in which your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Lovell Dental.

Lovell Dental Legal Responsibilities: As mandated by Federal and State legal requirements your health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, is in effect as of April 14th, 2009 and must be followed by our practice. This notice will be in effect until it is revised or replaced. We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Protected Health Information use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These professional, provider performances and evaluation practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation. Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used to disclose to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent, you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communication is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may need to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail, text messages, postcards, or letters.

PATIENT RIGHTS:

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation of why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.
If at any time, you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Patient Name: (first)_______________ (last)__________________________ **Date of Birth:** ______________

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Parent/Guardian (if patient is a minor) **Signature** **Date:**