LAKE GROVE DENTAL

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other _____
Full Legal Name

Preferred Name _____ E-mail _____

Gender: _____ Preferred Pronouns: _____ Birthdate _____ SSN# _____

Address _____ Occupation _____

City _____ ST _____ Zip _____ Mobile # _____

Employer _____ Home or Other Phone # _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated [ ] Other _____

Emergency Contact Name _____ Relationship _____ Phone# _____

RESPONSIBLE PARTY (Only complete if different than the patient above) Relationship to patient: _____

Name _____ Address _____
First MI Last

Email _____ City _____ ST _____ Zip _____

Mobile Phone# _____ Wk# _____ Birthdate _____ SSN# _____

Responsible Party Signature: _____

DENTAL BENEFITS INFORMATION: As a courtesy to our patients, we bill your dental benefits carriers directly. It is your responsibility to understand your coverage, maximum, and exclusions. We will go out of our way to help you know what you have at your request. Your insurance is a contract between you and your insurance company. Benefits are frequently based on your insurance's contract and may not reflect on your best treatment options.

STUDENTS WITH BENEFITS: Status: [ ] Full-time [ ] Part-time School Name & City _____

DENTAL BENEFITS (A photocopy of your card may suffice)

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Policy ID# _____ Employer _____

Insurance Co. Name _____ Ins. Co. Address _____

City _____ ST _____ Zip _____ Group # _____ Eff. Date _____

SECONDARY DENTAL BENEFITS? [ ] Yes [ ] No If yes, please complete the following:

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Policy ID# _____ Employer _____

Insurance Co. Name _____ Ins. Co. Address _____

City _____ ST _____ Zip _____ Group# _____ Eff. Date _____

Caring for More Than Just Your Teeth

Good oral health benefits your whole-health

Dental Health History Form For Patients New to Lake Grove Dental — Giving us a complete picture of your previous dental care and medical information helps us provide you with more complete care. Your oral health is linked to your total health, and you deserve the best. All of us at Lake Grove Dental want to make sure you receive it!

Tell us how you heard about us: _____

Reason for Visit: □ Broken tooth □ Check-up/Cleaning □ Cosmetic □ Tooth Pain □ Second Opinion □ Dentures

□ Implant □ Other _____

What has your past experience with dentistry been like? _____

_____

Approximately, when was your last continuing care visit (cleaning or periodontal cleaning) _____

Are you experiencing dental pain now? Yes ___ No ___ If yes, describe _____

Have you ever been pre-medicated for dental treatment? Yes ___ No ___ If so, what for? _____

If you are anxious about dental treatment or have worries about your oral health or smile, please do not hesitate to share them with us. We want you to be comfortable and address any concerns you may have.

□ Swollen/bleeding gums
□ Mouth Sores
□ Clenching or grinding
□ Discolored teeth
□ Crowding/crooked teeth
□ Missing teeth
□ Spaces in-between teeth
□ Loose tooth/teeth
□ Tooth shape/size
□ Unhappy w/look of teeth
□ Overbite
□ Underbite

□ Bite feels off
□ Old fillings (gold or silver)
□ Old crowns
□ Speech problems
□ Too much gum tissue showing
□ Gums receding
□ Tooth sensitivity
□ Food gets caught in teeth
□ Bleeding when you floss/brush
□ Difficulty chewing
□ Bad breath
□ Wear an occlusal guard at night

□ You had orthodontia in the past
□ You currently wear a permanent retainer
□ You wear removeable dental devices
□ You currently wear a snore device
□ You use a C-pap machine
□ You have had gum surgery or deep cleanings. If so when? _____
□ Other, describe _____

_____

_____

_____

Check any topics you are interested in learning about:

□ Teeth whitening
□ Orthodontic treatment
□ Veneers
□ Dental care during pregnancy

□ Tooth-colored fillings
□ Dental Implants
□ Preventing periodontal disease
□ Oral hygiene for infants and/or seniors

□ In-house Loyalty Plan for the uninsured
□ Other, describe_____

_____

_____

MEDICAL INFORMATION

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Cardiovascular

- □ A-Fib
- □ Heart Valve Replaced
- □ Coronary Artery Disease
- □ Chest Pain or Angina
- □ Congestive Heart Failure
- □ Heart Attack
- □ Heart Murmur
- □ Heart Stent Installed
- □ High Blood Pressure
- □ High Cholesterol
- □ Irregular Heartbeat
- □ Low Blood Pressure
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Tachycardia

Endocrine

- □ Diabetes
- □ Pre-Diabetic
- □ Gout
- □ Hormonal Change
- □ Thyroid problems

Eyes, Ears, Nose and Throat

- □ Change in Hearing
- □ Change in Vision
- □ Ear Pain
- □ Glaucoma
- □ Hay Fever
- □ Nasal Obstruction
- □ Nose Bleeding
- □ Sinus Problems
- □ Tonsillectomy
- □ Tinnitus (Ringing)

Gastrointestinal

- □ Acid Reflux
- □ GERD
- □ Soft or Special Diet
- □ Ulcers

Genitourinary

- □ Frequent Urination
- □ Kidney disease
- □ Nocturia
- □ Dialysis

General

- □ Cancer, if yes describe _____
- □ In Cancer Treatment Now Describe: _____
- □ General Weakness
- □ Fatigue/Tired
- □ Headaches
- □ HIV/STD List: _____
- □ Knee/hip replacement
- □ Liver Disease/Problems
- □ Recent Trauma or Injury
- □ Rheumatic Fever
- □ Radiation Treatment
- □ Unexplained Weight Change
- □ Swollen ankles
- □ Organ Transplant – List: _____

Hematological

- □ Bleeding problems
- □ Hepatitis Type _____
- □ Last A1C score _____

Oral

- □ Bleeding Gums
- □ Dry Mouth
- □ Sjogren's Syndrome
- □ Jaw Problems (TMJ)
- □ Jaw Clicking
- □ Jaw Pain
- □ Difficulty Swallowing
- □ Difficulty Chewing
- □ Has Had Orthodontics
- □ Periodontal Disease
- □ Teeth Clenching/Grindin
- □ Tooth Pain
- □ Wisdom Tooth Extraction
- □ Removable Teeth
- □ Wears a nightguard
- □ Wear Ortho Retainer(s)

Musculoskeletal

- □ Artificial Joint
- □ Arthritis
- □ Back Pain
- □ Fibromyalgia
- □ Joint Pain
- □ Osteopenia
- □ Osteoporosis
- □ Spinal Surgery

Neurological

- □ Alzheimer's Disease
- □ Dizziness
- □ Epilepsy
- □ Fainting
- □ Memory Loss
- □ Multiple Sclerosis (MS)
- □ Muscle Weakness
- □ Seizures
- □ Stroke Date _____
- □ Tingling/Numbness
- □ Trigeminal Neuralgia
- □ Tremor

Psychiatric

- □ ADD/ADHD
- □ Anxiety
- □ Chemical Dependency
- □ Depression
- □ Autism
- □ Eating Disorders
- □ Excessive Stress
- □ Memory Problems

Respiratory

- □ Asthma
- □ Bronchitis
- □ Breathing Problems
- □ Chest Pressure
- □ COPD
- □ Congestion
- □ Dyspnea (shortness of breath)
- □ Emphysema
- □ Orthopnea (Can't Lay Flat)
- □ Pneumonia
- □ Pulmonary Embolism
- □ Tuberculosis

Sleep

- □ Daytime Sleepiness
- □ Morning headaches
- □ Others say you snore
- □ Sleep Study Done - Results:
  - o Mild
  - o Mod
  - o Severe
  - o No Apnea
- □ Obstructive Sleep Apnea
- □ Do you use a CPAP? If so, how often? _____
- □ Wear oral device for sleep apnea?

Habits

- □ Alcohol
  - o Less than 1/day
  - o More than 1/day
- □ Smoke or Chew currently Qty: _____
- □ Former Smoker, when quit Year: _____
- □ Vape currently
- □ Recreational Drugs
- □ Special Diet

ANY Other Not Listed:

_____

_____

_____

This information will not be shared without the express authorization of the patient. Updates are required every two years or when there are significant health changes.

In a few words, how would you describe your overall health? _____

Has there been a change in your health or the medications you take in the last two years? Please describe: _____

_____

Have you gone to the hospital or had a serious illness in the last two years? Why/what? _____

Are you being treated by a physician now? Yes ____ No ____ If yes, for what? _____

When was your last physical? _____ Physician's Name/City _____

Your current weight? _____ Your height? _____ Women: Are you or could you be pregnant? Due Date _____

Do you have any pain in your body now? Yes____ No____ If yes, describe _____

Do you currently need to be premedicated for dental treatment? Yes ___ No ___ If so, for what? _____

Emergency contact: Name _____ Relationship _____ Phone _____

Allergies: Are you allergic to or had a reaction to:

- ☐ Local anesthetic
- ☐ Foods– Describe _____
- ☐ Penicillin
- ☐ Other Antibiotics _____
- ☐ Sulfa drugs
- ☐ Metal(s)- Describe _____
- ☐ Tranquilizers/Sedatives
- ☐ Aspirin _____
- ☐ Codeine or other narcotics
- ☐ Latex
- ☐ Other – Please list any

_____

_____

_____

Have you ever experienced anaphylaxis? Yes___ No___ If so, what triggered the episode? _____

Medication Information

Are you currently, or have you taken in the past, medications for bone density? Yes ____ No ____

Please list all medications and supplements (vitamins) you are currently taking or provide a printed list: _____

_____

_____

_____

_____

_____

I certify that I have read and understand the entire medical and dental history forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist and his staff of any changes in my health and/or medications. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of these forms.

Signature of Patient (or Guardian) _____ Date _____

Signature of Healthcare Provider _____ Date _____

Consents and Policies

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Charles Branen, DMD (dba Lake Grove Dental) to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Charles Branen, DMD to perform forms of treatment, medication, and therapy that may be necessary and further consent that Charles Branen, DMD choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Charles Branen, DMD. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS WHEN APPLICABLE: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). Insurance benefits are an agreement between myself and my carrier; I know it can only be estimated, and it is not a guarantee of payment by my carrier. I further consent to and agree to pay a 1.5% finance charge (18% annually) that may be applied to any balance over 60 days. I acknowledge that I am responsible for all fees necessary to collect my account. To the extent permitted by law, I consent to Charles Branen, DMD and his staff use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Lake Grove Dental for the dental benefits otherwise payable to me.

APPOINTMENT POLICY: I understand that Charles Branen, DMD requires 48 hours-notice to cancel or change a scheduled appointment or that fees may apply. For chronically missed/canceled appointments I may be dismissed from the practice. (See the policy on our website: www.lakegrovedental.com/financial-information/appointmentpolicy/)

By signing below, I agree to the policies shown above:

Patient Name _____ **Date** _____

Patient/Guardian Signature_____ **Date**_____
Signature of Parent/Guardian

NOTICE OF PRIVACY PRACTICES: (Consent to Share Personal/Financial Information)
Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing you are acknowledging receiving notice of our practices' policies and your rights regarding PHI (available on our website: www.lakegrovedental.com/financial-information/privacypolicy/). I agree to allow release of pertinent medical records to my insurance company (if applicable) and my other medical/dental providers.

Sometimes patients wish their information to be shared w/other designated persons. This info may be revised at any time. Please complete the following and mark what info may be shared and with whom. Leave the following two lines blank if you do NOT wish your information shared.

Name: _____ Relationship: _____ Medical: Y N Financial: Y N

Name: _____ Relationship: _____ Medical: Y N Financial: Y N

By signing below, I agree to Notice of Privacy Practices above:

Patient Name _____ **Date** _____

Patient/Guardian Signature_____ **Date**_____
Signature of Parent/Guardian