Lake Grove Dental

Patient Information

Name: _____ Pronunciation: _____
Last First Middle

Preferred name: _____ Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Child

Date of birth: _____ Gender: ☐ F ☐ M ☐ Other S.S. or Driver's license#: _____

Address: _____
City State Zip

Phone: _____ Email: _____

How did you hear about Lake Grove Dental? _____

Employer: _____ Occupation: _____ Wk Phone: _____

In case of emergency, who should be notified? _____ Phone: _____

Appointment confirmation pref: ☐ Text ☐ Email ☐ Phone call ☐ No Contact ☐ Other _____

Primary Dental Benefits

(Subscriber's Information)

Subscriber To Insurance: _____ Birth date: _____
Last First M.I.

Relation to Patient: _____ S.S.# or Ins. ID #: _____

Employer: _____ Group #: _____ Payor ID #: _____

Insurance Co. Name: _____ Ins. Co. Phone: _____

Ins. Co. Address: _____
City State Zip

Secondary Dental Benefits

(Subscriber's Information)

Subscriber To Insurance: _____ Birth date: _____
Last First M.I.

Relation to Patient: _____ S.S.# or Ins. ID #: _____

Employer: _____ Group #: _____ Payor ID #: _____

Insurance Co. Name: _____ Ins. Co. Phone: _____

Ins. Co. Address: _____
City State Zip

Patient or Guardian's Signature: _____ Date: _____

Lake Grove Dental

Comprehensive Oral and Systemic Health History

Focused on Progressive Dental Wellness and Your Overall Health

Name_____Date of Birth_____Today's Date_____

What is your most important concern today? _____

How frequently do you brush your teeth each day? ☐ 0 ☐ 1 ☐ 2 ☐ 3+

How often do you floss each day? ☐ 0 ☐ 1 ☐ 2 ☐ 3+

Oral Condition:

Do you have any missing teeth other than wisdom teeth? ☐ Y ☐ N
Do you ever experience discomfort when chewing? ☐ Y ☐ N
Do your jaw joints click, pop or make grinding sounds? ☐ Y ☐ N
Do your jaw joints ever get stuck or locked? ☐ Y ☐ N
Do you experience frequent headaches or jaw/facial pain? ☐ Y ☐ N
Have you ever been treated for a jaw joint problem? ☐ Y ☐ N
If so, by what methods?: _____
Do you wear any removable dentures or partial dentures? ☐ Y ☐ N
If so, are they comfortable and well-fitting? ☐ Y ☐ N
Are your gums sore or swollen? ☐ Y ☐ N
Do you have sensitivity to sweets, hot or cold? ☐ Y ☐ N
Do you have a persistent sore throat or ear pain? ☐ Y ☐ N
Do you have unexplained numbness or pain? ☐ Y ☐ N
Do you clench or grind your teeth? ☐ Y ☐ N

Oral Cancer:

Do you have any persistent sore spots on your mouth or lumps/ bumps in your head, cheek or neck? ☐ Y ☐ N
Do you feel as if you have a persistent lump in your throat? ☐ Y ☐ N
Women: Do you average two or more alcohol drinks per day? ☐ Y ☐ N
Men: Do you average three or more alcohol drinks per day? ☐ Y ☐ N
Are you a current smoker? ☐ Y ☐ N Packs per day? _____
Are you a former smoker? ☐ Y ☐ N When did you quit? _____
Chronic exposure to secondhand smoke? ☐ Y ☐ N
Are you currently chewing tobacco? ☐ Y ☐ N
If so, how much? _____
Do you need help quitting? ☐ Y ☐ N
Are you a former chewer? ☐ Y ☐ N When did you quit?_____
Do you use recreational drugs? ☐ Y ☐ N
Any sores/lesions in your mouth longer than 2 weeks? ☐ Y ☐ N

Pre-Diabetes and Diabetes:

Do you feel thirsty frequently? ☐ Y ☐ N
Have you ever been diagnosed with prediabetes or diabetes? ☐ Y ☐ N
Do you take medications for diabetes? ☐ Y ☐ N
What was your last HgA1c number? _____
Do you have any biologic family members with diabetes? ☐ Y ☐ N

Caries (tooth decay):

Do you consider yourself cavity prone? ☐ Y ☐ N
Do you consume sugary foods or beverages regularly? ☐ Y ☐ N
Do you consume any citrus flavored beverages? ☐ Y ☐ N
Do you have trouble with a dry mouth? ☐ Y ☐ N

Sleep:

Do you or your partner ever snore? ☐ Y ☐ N
Experience interruptions in breathing during sleep? ☐ Y ☐ N
Have difficulty sleeping? ☐ Y ☐ N
Feel tired or fatigued during the day? ☐ Y ☐ N
Do you have chronic hoarseness? ☐ Y ☐ N
Do you breathe from your mouth? ☐ Y ☐ N
Have a sleep study history? ☐ Y ☐ N
Have a CPAP or oral sleep appliance? ☐ Y ☐ N
Do you depend on any prescription or non-prescription drugs to sleep or wake? ☐ Y ☐ N

Periodontal Disease:

Have you been told you have gingivitis or gum disease in the past? ☐ Y ☐ N
Do your gums ever bleed when you brush or floss? ☐ Y ☐ N
Do you have gum recession or exposed root surfaces? ☐ Y ☐ N
Do you feel like your teeth look longer? ☐ Y ☐ N
Do you have any loose teeth, drifting teeth, or areas that collect food when you eat? ☐ Y ☐ N
Do you have any teeth that feel loose? ☐ Y ☐ N

Nutrition and Lifestyle

How would you rate your nutrition/diet?
1 (poor)-10 (excellent) ..... _____
Do you have any eating disorders? ☐ Y ☐ N
Do you take dietary supplements? ☐ Y ☐ N
Do you snack frequently? ☐ Y ☐ N
Do you have gum, mints, or cough drops regularly? ☐ Y ☐ N
Do you follow a special diet? ☐ Y ☐ N
What sugary foods or drinks do you consume regularly?

List any other beverages you consume on a regular basis:

General Health:

How would you rate your overall health?
1 (poor)- 10 (excellent) …….. _____
How important is health to you?
1 (not at all) – 10 (highest priority) …….. _____
Has your health changed in the past year? ☐Y ☐N
Any serious illness or hospitalizations in the past five years? ☐Y ☐N
Any chronic ongoing or recurrent illness? ☐Y ☐N
Your weight_____Your height _____
Are you currently being treated for any medical conditions? ☐Y ☐N
Please describe if the answer is yes:

Have physicians told you to be premedicated for dental visits? ☐Y ☐N
Are you aware of or being treated for any vital organ disease such as diseases of the thyroid, lungs, liver, kidneys, brain, etc.? ☐Y ☐N
Please list your general physician and any other health care providers currently caring for you:
Name_____Phone_____
Name_____Phone_____
Name_____Phone_____
Female: Are pregnant or planning pregnancy? ☐Y ☐N
Taking birth control pills? ☐Y ☐N
Are you nursing? ☐Y ☐N
In menopause? ☐Y ☐N
Male: Erectile dysfunction? ☐Y ☐N

Allergies, Sensitivities, and Other Conditions:

Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, arthritis, chronic fatigue syndrome, insulin resistance, or periodontal/gum disease? ☐Y ☐N
If so, please list : _____
Are you aware of any allergies, including medications? ☐Y ☐N
If so, please list: _____
Do you have asthma? ☐Y ☐N
Have you identified any food sensitivities such as dairy, wheat or soy? ☐Y ☐N
Do you suffer from GI disturbance such as discomfort, bloating, constipation or diarrhea? ☐Y ☐N
Do you ever have heartburn or regurgitation? ☐Y ☐N
Do you have difficulty losing weight despite real effort? ☐Y ☐N
Do you regularly eat foods that make you feel sluggish, sick? ☐Y ☐N
Do you have red, patch or itchy skin, or itch ears? ☐Y ☐N

Medications (List all you are taking):

Cardiovascular Health:

Are you currently being treated for high blood pressure or cardiovascular disease? ☐Y ☐N
Have you had any heart valves replaced? ☐Y ☐N
Do you have a history of heart attack, stroke, bypass surgery or stents? ☐Y ☐N
Do you experience shortness of breath or chest pain? ☐Y ☐N
Do you have a family history of heart disease? ☐Y ☐N
Do you take anti-cholesterol medicine? ☐Y ☐N
Have you ever been diagnosed or treated for high blood pressure? ☐Y ☐N
If so, is it currently controlled? ☐Y ☐N
Do you currently take blood pressure medicine? ☐Y ☐N
Do you monitor your own blood pressure? ☐Y ☐N

Bone & Joint Health:

Have you been diagnosed with osteopenia or osteoporosis? ☐Y ☐N
Have you had an abnormal bone density test? ☐Y ☐N
Have you been treated with oral or injectable medications for osteoporosis? ☐Y ☐N
If yes, which ones? _____
Do you suspect vitamin D deficiency? ☐Y ☐N
Do you have joint inflammation, pain or arthritis? ☐Y ☐N
Have you had a history of joint surgery or joint replacement? ☐Y ☐N
If so, when? _____

Brain Health:

Have you been diagnosed with dementia, depression, anxiety disorder or any other brain function ailment? ☐Y ☐N
Do you frequently feel sad, energy depleted or anxious? ☐Y ☐N
Lost interest in activities that used to make you happy? ☐Y ☐N
Do you experience "brain fog" where your awareness of surroundings seems dulled? ☐Y ☐N

Dependency/Addiction:

Are you currently in recovery or being treated for addiction? ☐Y ☐N
Do you consume caffeine in excess of three cups per day? ☐Y ☐N
Do you feel you are addicted to sugar? ☐Y ☐N
Do you routinely need pain pills to control pain? ☐Y ☐N

Cancer:

Do you have a cancer diagnosis or history? ☐Y ☐N
Are you currently undergoing cancer treatment? ☐Y ☐N
Do you currently have a suspicion or fear of cancer in your body? ☐Y ☐N
Do you have any known risk factors for a specific cancer? ☐Y ☐N
If yes, which one(s): _____

To the best of my knowledge and memory, I have accurately answered the questions on this form:

Signature:_____Date: _____

Lake Grove Dental

Financial Agreement

We are committed to providing our patients receive the needed treatment to achieve and maintain optimal dental health. We offer the following financial agreement and payment options:

For our patients with dental benefits:

Initial _____ Dental "insurance" benefits are an agreement between you and your insurance company; therefore we can only estimate your dental benefits. This estimate is not a guarantee of payment by your insurance company. You are responsible for any charges your insurance company does not pay and that we are not contractually obligated to adjust.

Initial _____ Your out of pocket and deductibles are due at time of service unless other arrangements made.

Initial _____ Insurance payments not paid after 60 days will become your responsibility. You agree to pay your full balance after 60 days from date of service. We file claims electronically and usually receive payment within 30 days.

For our patients without dental benefits:

Consider joining our Loyalty Plan. In some cases it is superior to commercial insurance plans (see details in the office or go to https://www.dentalhq.com/accounts/signup/my-dentist/1990). No maximums, limitations or deductibles apply.

For uninsured, non-Loyalty member patients, we offer a 5% courtesy for payment at time of service.*

Financing options:

1. We accept cash, check and all major credit cards
2. We accept payments from HSA and FSA cards
3. We also offer financing options with no interest payment up to 12 months with CareCredit, when approved

*We offer some products and services at cost. These items are not subject to further discounts.

Patient Appointment Policy Agreement

In order to accommodate requests for appointments from every new, existing and emergency patient and to ensure that we have providers in the practice to accommodate these requests, we ask you to give our practice a minimum of 48 hours' notice if you realize you will be unable to keep your scheduled appointment or need to make a change to it.

As a courtesy to you, we make every effort to remind you, in some way, of your upcoming appointment (text, email, phone, mail). The way in which we communicate with you may be tailored to your specifications. A fee will be charged for appointments missed or rescheduled without the 48 hours' notice. Please see our Patient Appointment Policy (attached to this clipboard or request) for further information about fees and practices.

Our commitment to excellence is delivered through our high clinical standards, as well as our appointment management guidelines. With your compliance, we will be more able to keep our schedule "on time", accommodate any emergencies and help patients on our waiting list. Thank you for agreeing to support our appointment policy.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that chronically missed and /or canceled appointments may result in a fee or dismissal. I authorize Lake Grove Dental to bill my insurance company as well as release any information needed to do so and assign benefits to Charles L. Branen, DMD, PC.

Printed Name: _____ **Signature:** _____ **Date:** _____

Lake Grove Dental

Acknowledgement of Receipt of Privacy Notice and Consent to Share Instructions

Acknowledgement of Receipt of Privacy Notice

I,_____, have read, received and/or have been offered a copy of Lake Grove Dental's PRIVACY POLICY NOTICE (available in the office and on our website: www.lakegrovedental.com/cancelation-hipaa-policies) and consent to the use of my protected health information to carry out treatment, payment activities, and healthcare operations as explained. I understand that my information will not be disclosed in any way not outlined in the above mentioned policy, unless I have given written consent, which may be revoked at any time by me, in writing. This includes, but is not limited to, my spouse, mother, father and/or siblings. If under age 18, information will be shared with parents and/or legal guardians.

Patient Name _____ Date _____

Patient Signature or Parent/Guardian Signature _____

Consent to Share Personal/Financial Information

Patients age 18 and older: Sometimes patients wish their information to be shared with other designated persons. Please complete the following and mark what information may be shared and with whom. This information may be revised at any time. If there is no one you consent to share information with, please leave section blank and do not sign. I give consent to share my information with the following parties, should they inquire:

☐ Spouse:_____ Personal: ☐ YES ☐ NO Financial: ☐ YES ☐ NO

☐ Parent:_____ Personal: ☐ YES ☐ NO Financial: ☐ YES ☐ NO

☐ Other:_____ Personal: ☐ YES ☐ NO Financial: ☐ YES ☐ NO

☐ Other:_____ Personal: ☐ YES ☐ NO Financial: ☐ YES ☐ NO

Patient Signature_____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our PRIVACY POLICY NOTICE, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prevented obtaining this acknowledgement

☐ OTHER: _____