LOL Dental & Orthodontics
1501 E. Loop 304, Ste. 100
Crockett, TX 75835
Phone: 936-544-0052, Fax: 936-243-6447

Patient Information

Please take a moment to enter your information to help us ensure the quality of your care is excellent.

Patient Name: _____
Last First MI Preferred Name

Birth Date: _____ Age: _____ Sex: _____ E-Mail: _____

Phone: _____ Cell/Alternate Phone: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Marital Status: ___ Single ___Married ___ Divorced ___ Remarried ___ Widowed

Patients Social Security Number: _____

Physician: _____ Physicians number: _____

Responsible Party Information

Person Responsible for Account: _____
Last First Middle

Relationship to Patient: _____ Birth Date: _____ Soc. Sec. #: _____

Address (If different from patient): _____

Phone: _____ Cell Phone/Alternate Phone: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Dental Insurance Company: _____ Insurance Phone: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID #: _____ Group #: _____

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Whom may we thank for referring you to our practice?

_____ Dental Office _____ Newspaper _____ Yellow Pages _____ Internet _____ School

_____ Work _____ Community Event _____ Friend/Family _____Facebook

Name of person, office, or other source referring you to our practice: _____

Employment Information

The following is for: _____ the patient _____ the person responsible for the payment

Employer Name: _____ Phone: _____

Address: _____

State: _____ Zip Code: _____

HIPPA

ACKNOWLEDGEMENT OF RECEIPT / REVIEW OF NOTICE OF PRIVACY PRACRTICES

I have received/reviewed a copy of this office Notice of Privacy Practices

**IT IS YOUR LEGAL OPTION TO NOT SIGN THIS ACKNOWLEDDGEMENT, HOWEVER OUR POLICY STATES THAT IF WE DO NOT HAVE THIS SIGNED ACKNOWLEDGEMENT FROM YOU, WE WILL NOT BE ABLE TO PROVIDE YOU WITH OUR SERVICES.

Signature: _____ Date: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:
_____ Individual refused to sign _____ Communication barriers prohibited acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement _____ Other

Name of office personnel: _____

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Transfer of Authority for Non Parent / Legal Guardian

Dental Treatment @ Lol Dental

I, _____, am the Parent/Legal Guardian of _____.

I am authorizing _____ to make any decisions on my behalf, in reference to my child, for dental treatment that may be required. I understand that any restorative treatment will not be completed, until I sign the original treatment plan. At the time, if I am unable to bring my child for any reason, the above listed person/ persons have my permission to make any judgement decisions pertaining to the treatment of my child. I understand that if my child requires any type of sedation, it is my responsibility to bring my child to any and all visits. I also understand I am responsible for any communication of medical changes in my child's history, and any medical releases that are Required by LOL Dental.

I understand LOL Dental's policy on Transferring Authority to another caregiver. I understand that the person/persons Listed above, are required to bring photo ID to be kept in my child's file at all times.

I can be reached at _____, if LOL Dental has any questions regarding the treatment of my Child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

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Medical History- For the following questions mark yes, or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper evaluation.

Now or in the past, have you had:

Yes No

__ __ Birth defects or hereditary problems
__ __ Bone fractures, any major accidents
__ __ Rheumatoid or arthritic conditions
__ __ Endocrine or thyroid problems
__ __ Kidney problems
__ __ Diabetes
__ __ Cancer, tumor, radiation treatment or chemo
__ __ Stomach ulcer or hyperacidity
__ __ Polio, mononucleosis, tuberculosis, pneumonia
__ __ AIDS or HIV positive
__ __ Hepatitis, jaundice or liver problems
__ __ Fainting spells, seizures, epilepsy or neurological Problem
__ __ Mental health disturbance r depression
__ __ Vision, hearing, tasting or speech difficulties
__ __ Loss of weight recently, poor appetite
__ __ History of eating disorder (anorexia, bulimia)
__ __ Excessive bleeding or bruising tendency, anemia or Bleeding disorder
__ __ High or low blood pressure?
__ __ Chest pain, shortness of breath or swelling ankles
__ __ cardiovascular problem (heart trouble, heart Attack, angina, coronary insufficiency, arteriosclerosis Rheumatic heart disease
__ __ Skin disorder
__ __ Do you have a well-balanced diet
__ __ Frequent headaches, colds or sore throat
__ __ Eye, ear or throat condition
__ __ Hayfever, asthma, sinus trouble or hives
__ __ Tonsil or adenoid conditions
__ __ Osteoporosis

Allergies or reactions to any of the following:

__ __ Local Anesthetics (Novocaine or Lidocaine)
__ __ Asprin, Ibuprofen (Motrin, Advil)
__ __ Penicillin or other antibiotics
__ __ Sulfa drugs
__ __ Codeine or other narcotics
__ __ Metals (jewelry, clothing snaps)
__ __ Latex (gloves, balloons)
__ __ Vinyl, Acrylic
__ __ Animals
__ __ Foods_____

Yes No

__ __ Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine?

Medication_____ Taken for _____
Medication_____ Taken for _____
Medication_____ Taken for _____
Medication_____ Taken for _____
Medication _____ Taken for _____
Medication_____ Taken for _____
Medication_____ Taken for _____
Medication_____ Taken for _____

__ __ Do you currently have or ever had a substance abuse problems?
__ __ Do you chew or smoke tobacco?
__ __ operations? Describe _____

__ __ Hospitalized? For _____

__ __ Other physical problems or symptoms? Describe _____

__ __ Being treated by another health care professional For _____
Date of most recent exam? _____

__ __ Do you have any other medical conditions that we should know about? _____

Women Only:

__ __ Are you pregnant
__ __ Are you anticipating becoming pregnant

Family Medical History:

Do your parents or siblings have or have you ever had any of the following health problems? If so, please explain:

__ __ Bleeding disorders __ __ Diabetes
__ __ Arthritis __ __ Severe allergies
__ __ Unusual dental problems
__ __ Jaw size imbalance

Any other family medical conditions that we should know about? _____

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FINANCIAL OFFICE POLICY

In consideration for the professional services rendered to me, I agree to pay for these services, at the time the services are rendered unless financial arrangements are made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of service. Our fee reflects our commitment to the quality of care that out patients deserve. I you have insurance, we are happy to assist you in processing your insurance claims to maximize your benefits. INSURANCE ESTIMATES will assist you in determining your APPROXIMATE OUT OF POCKET EXPENSE. Please note THAT INSURANCE ESTIMATES ARE NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY. We ask you to keep in mind that your insurance policy is a contract between your employer, yourself and the insurance company. We are not part of that agreement.

REGARDLESS OF INSURANCE COVERAGE, ALL FEES AND ACCOUNT BALNCES ARE THE PATIENTS RESPONSIBILITY.

As a patient of LOL Dental & Orthodontics, I understand my financial responsibility and also give consent to use this signature on all insurance claims, to release records, including X-rays for insurance purposes only. I also give you permission to contact me by phone or e-mail concerning any matter related to my treatment or account. I give consent for my dental treatment as deemed necessary.

APPOINTMENTS

We value your time so you can expect us to see you at the appointment time and to keep your time spent in our office as short as possible, in return, when you make an appointment with us please be on time since we have reserved our time just for you. **We reserve the right to reschedule your appointment if you arrive 15 minutes after scheduled appointment time.**

Please make every effort not to change your scheduled appointment time. If you must change an appointment, please provide us at least **2 working days** advanced notification so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

Our office will be calling scheduled appointments 2 days before the scheduled date to confirm appointment. Appointment will need to be confirmed in order to keep your scheduled appointment. If no confirmation is received 48 hours prior, the appointment will be lost.

After 3 missed appointments without proper notification of cancellation, 48 hours prior, the office does reserve the right to refuse the continuation of treatment, and the insurance company will be notified. Please be aware that certain insurance companies will deny coverage if dental benefits are not used and/or scheduled visits are missed.

Signature: _____ Date: _____

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of the patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements have been made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However this dental office cannot render services on the assumption that our charges will be paid by and insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date f the patient examination.

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 is extended. I further agree that the charges for services for service shall be billed unless objected to, by me, in writing within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I 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 this statement or my treatment.

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

Signature: _____ Date: _____

THANK YOU FOR CHOOSING LOL DENTAL & ORTHODONTICS!!