All About You

Patient's Name: ______________________________ Patient's Preferred Name: ______________

Birthday: ____________________ Social Security Number: ____________________ Sex: Male Female

Address ____ Apt #______________

City ____________ State __________ Zip Code _________ Referral Source: ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ______________________________ Marital Status: Single Married Divorced Widowed

Would you like to receive appointment confirmations via email or text message? Yes No

Emergency Contact: ______________ Relationship: __________ Phone Number: ______________

Billing/Responsible Party (to be filled out if the above patient is a minor)

Responsible Party's Name: ______________________________ Relationship to patient: __________

Birthday: ____________________ Social Security Number: ____________________ Sex: Male Female

Address ____

City ______________________________ State ____________ Zip Code ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ____

Primary Insurance Information

Subscriber's Name: ____________________ Insurance Company: ____________________

Birthday: ______________ Insurance Phone Number: ______________

Relationship to patient: ______________ Claims Mailing Address: ______________

Subscriber's Member ID: ______________ City: _______ State: _____ Zip Code: _____

Employer: ____________________

Secondary Insurance Information

Subscriber's Name: ____________________ Insurance Company: ____________________

Birthday: ______________ Insurance Phone Number: ______________

Relationship to patient: ______________ Claims Mailing Address: ______________

Subscriber's Member ID: ______________ City: _______ State: _____ Zip Code: _____

Employer: ____________________

Patient's Name: ______________________________ Birthday: ____________

Allergies (please mark (X) for your response to the following questions.)

Local Anesthetics	Yes No	Penicillin or other antibiotics	Yes No
Aspirin	Yes No	Sulfa Drugs	Yes No
Codeine or other narcotics	Yes No	Metals	Yes No
Latex (rubber)	Yes No	Other Allergies	Yes No

Dental History (please mark (X) for your response to the following questions.)

Do your gums bleed:	Yes No	Is your mouth dry?	Yes No
Do you grind your teeth or wear an occlusal guard?	Yes No	Have you had any periodontal treatment?	Yes No
Are your teeth sensitive?	Yes No	Have you had orthodontic treatment?	Yes No
Do you have click, popping, TMJ or jaw discomfort?	Yes No	Have you had any serious injury to your head or mouth?	Yes No
Have you had your wisdom teeth removed?	Yes No		

Previous Dental Provider's Name: ______________________ Phone Number: ____________

When was your last dental cleaning: ______________________ Were x-ray taken? ____________

How many times do you brush a day? ____________ How many times do you floss a week? ____________

Are you happy with your smile? ____________ If no, please explain ______________________

Do you have concerns about having dental treatment done? ________ If yes, please explain ____________

MADISON LAKES DENTAL

Patient's Name: ______________________________________ Birthday: ____________________

Medical History (please mark (X) for your response to the following questions.)

Abnormal Bleeding	Yes No	Angina	Yes No
AIDS/HIV	Yes No	Asthma	Yes No
Arthritis	Yes No	Cancer/Chemotherapy/Radiation	Yes No
Cardiovascular Disease	Yes No	Diabetes Type I or II	Yes No
Damaged Heart Valves	Yes No	Eating Disorder	Yes No
Epilepsy	Yes No	Fainting Spells/Seizures	Yes No
G.E. Reflux/heartburn	Yes No	Heart Murmur	Yes No
Hemophilia	Yes No	Hepatitis, Jaundice or Liver Disease	Yes No
High Blood Pressure	Yes No	Low Blood Pressure	Yes No
Mitral Valve Prolapse	Yes No	Pacemaker	Yes No
Persistent Swollen Glands in Neck	Yes No	Sexually Transmitted Disease	Yes No
Sleep Disorder	Yes No	Stroke	Yes No
Do you Snore?	Yes No	Use Tobacco?	Yes No
Have you had a **JOINT REPLACEMENT?**	Yes No		
If yes, do you require a PRE-MED?	Yes No		
Are you currently taking medications?	Yes No	If yes, please list ________________________________	
Are you taking blood thinners?	Yes No	If yes, please list ________________________________	
Women: Are you pregnant?	Yes No	If yes, Due Date ________________________________	

PLEASE LIST OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: ____

Name of Primary Physician: ____________________ Clinic location of primary physician: ______________________

I confirm the above information I have provided is correct and to the best of my knowledge. I understand it is my responsibility to inform Dane Dental of any changes in my personal information, insurance changes and medical status.

Print Patient's Name: ______________________________________ Date: ___________________________

Patient/Guardian's Signature: ______________________________________

ACKNOWLEDGEMENT RECEPIT NOTICE OF HIPAA PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for Madison Lakes Dental. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations.

The Notice of Privacy Practices also describes my rights and the responsibilities and duties of Madison Lakes Dental with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility. Madison Lakes Dental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY ____________________ ☐ YES ☐NO

SPOUSE/PARTNER ONLY ____________________ ☐ YES ☐ NO

OTHER (PLEASE SPECIFY) ____________________ ☐ YES ☐ NO

I understand that I have the right to terminate disclosure to have above person(s) at any time with a written request.

MY SIGNATURE BELOW ACKNOWLEDGES I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. ALL OF MY QUESTIONS HAVE BEEN ANSWERED AND I UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS ACKNOWLEDGEMENT AND/OR CHANGES IN THE ADDITIONAL DICLOSURE AUTHORITY AT ANY TIME

PRINT PATIENT'S NAME ____________________ **DATE** __________

PATIENT/GUARDIAN'S SIGNATURE ____________________

Financial Policy

Thank you for selecting Madison Lakes Dental as you dental health care provider. Our goal is to provide you with optimal dental care. We want you to feel welcome and comfortable throughout our relationship. We encourage you to ask questions and be involved in your treatment decisions. This includes understanding your treatment plan as well as our financial policy. Insurance Assistance Insurance companies can be difficult and challenging to understand. Our team will assist you with providing a treatment estimate. Please understand treatment estimates are provided to you as a courtesy and not a guarantee of benefits. Full benefits will be determined by your insurance company when the claim is submitted and processed according to your plan benefit. Madison Lakes Dental will not be liable for any services not covered by your insurance company. Payment: FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS AND DEDUCTIBLES WILL BE DUE AT THE TIME OF SERVICE. Unpaid balances over 30 days will be subject to monthly interest of 1.5% interest. Unpaid balances over 90 days will be forwarded to collections.

Financial Assistance We offer the following financial options for treatment

A. For patients who do not have insurance, we offer a courtesy discount of 5% if paid with cash or check. Payment must be made at the time the appointment is scheduled to receive the discount.
B. We accept all major credit cards such as Visa, MasterCard, Discover and American Express
C. We are pleased to partner with Care Credit for third party financing. To see if you qualify for Care Credit, please go to www.carecredit.com to apply.

Missed Appointments

At Madison Lakes Dental, we are truly fortunate to have wonderful patients. Please understand the appointment times are reserved for you and we strive to help with your dental needs. We are aware that life can present all of us with unexpected turns but we request, if possible, that you give us a 48-hour notice so that we may offer the time to someone in need of an appointment. If two or more appointments are missed without proper notice, we reserve the right to assess a "missed appointment" fee of $45.00 which will have to be paid prior to any appointments being scheduled.

By signing, I acknowledge I have read, understand and agree with the terms and conditions of this financial agreement.

Signature ______________________________ Date: ________________