Patient Information

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ SSN: _____
Employer Name: _____
Marital Status: (please circle) Single Married Divorced Widowed

Responsible Party / Insurance Information

Name of Parent/Insurance Policy Holder (if different from above): _____
Date of Birth: _____ SSN: _____
Employer Name: _____
Insurance Carrier Name: _____ Member ID: _____
Group #: _____ Insurance Phone #: _____
Do you have more than one insurance? (please circle) Yes No

Policy Holder Address (if different from above):

Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Phone #: _____

Referral Information: Whom may we thank for referring you to our practice? (please circle)

Another person (friend, relative, etc.) - please specify name: _____
Insurance *Internet Search/Google* *Yelp* *Live Nearby/Location*
Other (please specify): _____

CONSENT FOR SERVICES AND USE AND DISCLOSURE OF HEALTH INFORMATION

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Regardless of any dental insurance a patient may have, the full treatment fees are the responsibility of the patient, not the insurance company or the practice. Full payment of our fees is due at or before the time of treatment. I grant my permission to your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read this form, agree to its terms, and certify I have provided all information completely and accurately.

Signature of patient or parent/guardian (if a minor) _____

Relationship to patient (if applicable) _____ **Date** _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____
Female Patients only:
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

Signature: _____ Date: _____

LADY BIRD
DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (Print Name), have received a copy of this office's Notice of Privacy Practices.

_____
Responsible Party Printed Name

_____
Responsible Party Signature

_____
Date

_____
Emergency Contact Name and Phone Number

Please list anyone that Lady Bird Dental may discuss your treatment, appointments and/or financial obligations with (examples: parents, spouse, guardian or caretaker-specific names).

_____

May we leave detailed messages regarding treatment and/or appointments on your voicemail? (please circle one)

Yes No

For Practice Use Only

- ☐ Individual has refused to sign
- ☐ Communications barriers prohibited us from obtaining signed acknowledgement
- ☐ An emergency situation prevented us from obtaining signed acknowledgement
- ☐ Other (Please Specify) _____

LADY BIRD
DENTAL

Financial Policy

Thank you for choosing Lady Bird Dental for you the care of your dental health. Our primary mission is to deliver the most comprehensive dental care available in a caring and comfortable environment. An important part of our mission is making the cost of dental care accessible and manageable for our patients. We are happy to answer any questions regarding your visit with us today.

Payment Agreement

_____ (Initial) We accept Cash, Checks, Visa, MasterCard, Discover, and Care Credit (outside financing companies that offer no interest payment options).

_____ (Initial) Payment is due in full at each appointment. Patients are responsible for any amount insurance does not cover. We are contracted as an in-network provider with a number of insurance companies. Please see appendix for reference.

_____ (Initial) If you have a dental plan that gives you out-of-network benefits (allowing you to choose your own dentist), we will file your insurance claims for you as an out-of-network provider. You will be responsible for only your estimated portion at the time of service, plus any remaining balance unpaid by the insurance company.

_____ (Initial) If your insurance company pays you directly, we will collect in full for your visit and you will be reimbursed by the insurance company. If you have a DHMO or a DMO dental insurance plan, your visit will be self-pay.

Missed Appointment

_____ (Initial) If you need to cancel or reschedule an appointment, we kindly ask that you provide us a courtesy call at least 48 hours prior to your appointment so that we may offer the appointment to another patient. We may refuse to reschedule your appointment should you miss multiple appointments. Failure to provide 48 hours of advanced notice will result in $50 appointment fee. We kindly ask all our patients to arrive on time to their appointments.

By signing below, you agree to Lady Bird Dental's financial policy. We are honored that you have chosen our team to care for your dental health.

Patient Name (Print) _____

Patient (or Responsible Party) Signature _____ **Date** _____

RELEASE FOR USE OF PHOTOS AND LIKENESS BY LADY BIRD DENTAL

I understand that Lady Bird Dental ("the Practice") may take photographs of my dental condition before and after treatment. The Practice may wish to use such photographs for educational, promotional, advertising, and other purposes. This permission for release, without compensation or prior notice, would allow the Practice to use photographs in its printed publications, during presentations, and otherwise.

Therefore, I hereby freely and voluntarily consent to the use and publication of such photos taken by the Practice, without personally identifiable information, for any and all purposes including, but not limited to, educational, promotional, advertising, and trade. I further waive any claims against the Practice, its employees, or agents based upon or related to its use or publication of such photographs. I freely give this authorization without expectation of compensation.

Signature _____

Printed Name _____

Date _____