LOOKER FAMILY DENTAL

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your oral health.

PATIENT INFORMATION

Date_____ Patient's Name_____
Last First Middle

Address_____ City_____ State_____ Zip_____

Home Ph# (___)_____ Work Ph# (___)_____ Cell Ph# (___)_____

Soc. Sec. #_____ Email_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐Divorced ☐Widowed

If married, Spouse name_____ Home#_____ Cell#_____

Soc. Sec. #_____ Birthdate_____ Email_____

Whom may we thank for referring you? ☐Yellow Pages ☐Google ☐DexKnows ☐Walk in/Drive by ☐Insurance ☐Radio

☐ Referred By: _____ ☐Other: _____

In case of emergency who should be notified? _____ Phone(___)_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physicians care? ☐ Yes ☐ No If yes, why _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bisphosphonate Therapy
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Emphysema
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS/ARC
- ☐ Jaw Pain TMJ/TMD
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

Have you had any serious illnesses or operations not checked above? ☐ Yes ☐ No If yes, describe _____

_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking birth control pills/Hormone Therapy ☐ Yes ☐ No

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ Phone (____)_____

Circle if you have had problems with any of the following:

Bad breath	Sensitivity to Temperature	Bleeding gums	Wisdom Tooth Pain
Grinding	Sensitivity to Sweets	Clicking or jaw pop	Periodontal treatment
Loose Teeth	Sensitivity when Biting	Cold Sores	

How often do you brush? _____ How often do you floss? _____

Do you use any Tobacco products? Yes No If Yes, what product(s), how many years?_____

TREATMENT AUTHORIZATION

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify the above statements regarding my medical condition.

Patient or Parent/Guardian Print Name:_____ Date _____

Patient or Parent/Guardian Signature:_____

CONSENT FOR DENTAL TREATMENT OF MINORS IN ABSENCE OF PARENT/LEGAL GUARDIAN

I, _____, give Looker Family Dental permission to treat my child, _____

while I am not present. The individual/individuals bringing my child to their appointment are listed below and are at least 18 years old.

Accompanying Adult: Relationship to child:

_____

_____

_____

_____My child is of legal driving age and may be unaccompanied to dental appointments. I give consent for any and all dental treatment that has been previously discussed.

I give my authorization for all dental treatment, including routine procedures, that may be required during my absence: x-rays, exams, prophy, preventive procedures including fluoride, sealants, local anesthetic, fillings, as well as emergency dental treatment such as extractions, for the above-named child. I agree to pay for all services provided to my child.

This authorization shall remain in effective:
_____ One (1) year from date signed below

Or _____ Until _____ (Month, Day, Year)

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Looker Family Dental prior to this date. I also understand I will need to complete this form for each adult accompanying my child.

Parent/ Legal Guardian Signature: _____ Date: _____

ACCOUNT INFORMATION

Parent/Guardian Information _____

Last First Middle

Relation to Patient _____ Birthdate _____ Soc. Sec. #_____

Employed by_____ Employer Phone (___)_____

Single Married Divorced Widowed

Primary Dental Insurance Information

Policy Holder Name_____ Birthdate_____Soc.Sec#_____

Employed by_____ Employer Phone (___)_____

Insurance Company_____Group #_____Insurance Phone (___)_____

Is patient covered by additional dental insurance? Yes No

If yes, please complete the following secondary insurance information.

Insured's Name _____ Relation to Patient _____

Insured's Soc. Sec. # _____ Insured's Birthdate _____

Insurance Company_____ Group #_____

OFFICE FINANCIAL POLICY

Payment is expected at the time of service unless prior arrangements have been made. We will accept cash, check, credit card (Mastercard, Visa, American Express, Discover, Venmo, GooglePay). Please see front office staff to set up payment arrangements (if necessary).

I agree to pay a finance charge of 1.5% per month (18% per annum) on all unpaid balances commencing 30 days from the service date. In addition, I agree to pay any additional charges related to the cost of collection including reasonable attorney's fees and any collection agency fees which may equal 50% of any unpaid amount due in the event that I would fail to pay my bills.

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

**We will file pre-treatment estimates, at your request only.

Print Name_____ Signature _____ Date_____

MISSED APPOINTMENT POLICY

Due to the high number of patients requiring dental care, waiting times for appointments can be long. Because of this, we enforce a missed appointment policy to ensure that other patients receive care in a timely manner. Missed appointments and appointments cancelled without 24-hour notice are subject to a cancellation fee of $35.

Print Name_____

Signature_____ Date_____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the dentist.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ on this date _____ / _____ / _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force. In addition, I consent and allow the persons listed below to obtain my records upon request.

I allow my records to be released to (list all) _____

Print Name: _____

Signature: _____Date: _____

LOOKER FAMILY DENTAL

RECEIVE APPOINTMENT REMINDERS VIA TEXT OR EMAIL

Please check if you would prefer to receive reminders via text, email or both.

- ☐ Email
- ☐ Text
- ☐ Both

Email address: _____

Cell phone number: _____

(Must reply with "confirm" when prompted.)

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Looker Family Dental in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreement to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Looker Family Dental in the administration of your benefits. Our affiliates do not sell, share or rent our patients' personally identifiable information unless required by law, do not send email or other communications without your permission and do not send spam.

Please sign that you agree to allow us to use this information in providing your services.

Print name:_____

Signature: _____ Date: _____

LOOKER FAMILY DENTAL

SMILE QUESTIONNAIRE

These questions are designed to appraise your teeth and how you feel about smiling. Please answer honestly so we can better treat your concerns.

Are you unhappy with the appearance of your smile?	Yes	No
Are any of your teeth yellow, stained, or discolored?	Yes	No
Would you like your teeth to be whiter?	Yes	No
Do you have spaces or gaps between your teeth?	Yes	No
Are you missing any teeth?	Yes	No
Do you have any old fillings or dental work that you don't like?	Yes	No
Are any of your teeth worn, chipped, crowded/uneven or misshapen?	Yes	No
Are your gums sore, red, puffy, bleeding or receding?	Yes	No
Does the appearance of your smile inhibit you from smiling or laughing?	Yes	No

Please list or explain any additional concerns:

_____

_____

_____

_____

_____

_____