Lake Dental
Gentle Dentistry

Thank you for choosing our office to assist you with your dental needs.

Please fill out the information and don't forget to provide your signature at the end.

Patient's Name:_____ Date of Birth:_____

Sex:_____ If minor, Name of Legal Guardian: _____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Email address:_____

Employer:_____ Who referring you?_____

Insurance Information: ☐ Not covered by dental insurance Member ID#_____

Dental Insurance Co. _____ Group Number: _____

Claims Address:_____

Covered By Spouse/ Parent? ☐ YES or ☐ NO Subscribers Name:_____

Subscribers DOB:_____ Subscribers SS# or Member ID: _____

Medical Health History

Do you have, or have you had any of the following?
(Please check all that apply)

- ❑ **Are you required to rre-medicate before any dental treatment?**
- ❑ Blood Problems (Anemia)
- ❑ Blood Transfusion
- ❑ Heart Problems
- ❑ Heart Murmur, mitral valve prolapse, heart defect
- ❑ Pacemaker
- ❑ Stroke
- ❑ Bone or Joint Problems
- ❑ Artificial Joint or valves
- ❑ High or Low blood pressure (Circle One)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, Jaundice or other liver diseases
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or Cold Sores
- ❑ AIDS or HIV positive
- ❑ Cancer/Tumor
- ❑ Abnormal bleeding after surgery (heavy bleeder)
- ❑ Hay Fever or sinus trouble
- ❑ Allergies
- ❑ Asthma
- ❑ Chemical Dependency € In Recovery?

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Please List All Current Medications:

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Do you smoke, vape, or use tobacco? YES or NO

Women:

- ❑ Taking hormones or contraceptives
- ❑ Are you pregnant or plan to become pregnant?

Name of Primary Care Physician: _____ Phone #: _____

Dental History

Reason for today's Visit: _____ Date of last Dental Care:_____

Former Dentist: _____ Date of recent Dental X Rays:_____

Address: _____

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

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding Teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to Hot
- ❑ Sensitivity to Sweets
- ❑ Sensitivity when biting
- ❑ Sores or growth in mouth

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

Authorization

I certify that I, and/or my dependents have coverage with _____ and assign directly
(Name of Insurance Company)
to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my healthcare information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of patient/guardian or personal rep. **Date**

_____ _____

Print patient/ guardian or personal rep. **Relationship to patient**

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Page 1 of 2)

1. **Client's name**: _____
   First Name Middle Name Last Name

2. **Date of Birth**: ____/___/___ 3. **SSN**: ____-____-_____ 4. **Date authorization initiated**: ___/___/___

5. **Authorization initiated by**: _____
   Name (client or provider) (If provider, please specify relationship to client)

6. **Information to be Used or Disclosed**:

   ☐ My dental information relating to the following treatment or condition: _____

   ☐ Most recent ___ years of record

   ☐ My dental records for the following date(s): _____

   ☐ Entire dental record

   ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse

   ☐ Include ☐ Exclude: My health information related to HIV/AIDS

   ☐ Other information to be used or disclose (describe information in detail): _____

   _____

   _____

7. **Purpose of Use or Disclosure**:

   ☐ Treatment, Payment or Health Care Operations

   ☐ Disclosure to Life Insurer for Coverage Purposes

   ☐ Disclosure to Employer of results of pre-employment physical or lab tests

   ☐ Marketing Purposes

   ☐ To the Following Family Members: _____

   ☐ Other (describe each purpose of the requested use and disclosure in detail): _____

   _____

   _____

8. **Person(s) Authorized to Make the Disclosure**: _____

9. **Person(s) Authorized to Receive the Disclosure**: _____

10. **This Authorization will: ☐ not expire, ☐ expire on ___/___/___ or ☐ upon the happening of the following event**:

    _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the Client: _____

Signature of Personal Representative: _____

Relationship to Client if Personal Representative: _____

Date of signature: ___/___/___

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

   _____
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Lake Dental

3000 Lake St.
Lake Charles, Louisiana 70601
337-474-0210

PATIENT PAYMENT AGREEMENT

Thank you for the opportunity to help you meet your oral health goals. During our discussion of your treatment recommendation and our Written Financial Policy, the following financial arrangements were made:

The cost of treatment with Dr. Jon A. Feerick, D.D.S. is $_____. It is estimated that your insurance will cover $_____ and patient responsibility for treatment is $_____. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment. _____

(Patient initials)

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider. In the case that my insurance does not reimburse the full amount noted on the Treatment Plan, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

As you know, it is this practice's policy to receive payment prior to completion of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. You have agreed to pay your patient portion of the treatment fee in the following way:

- ( ) Payment in full in the amount of $_____

  Paid with: _____

- ( ) Deposit required: $_____

  Deposit paid with: _____

  Remaining treatment fee: $_____

- ( ) To be paid by: _____ with _____

- ( ) ___ Equal payments of $_____

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Lake Dental

3000 Lake St.
Lake Charles, Louisiana 70601
337-474-0210

No show, missed appointment office policy form

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of _____ per hour for not showing up for scheduled appointments.

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Credit card appointment reservation form

Please take notice. The card that is provided below will be charged on the day of your scheduled appointment only if your appointment is not cancelled within the requested 24 hour notice policy.

Credit Card # _____

(Circle One) – M/C – Visa – Disc – Amex

Expiration Date- _____

CC Security Code (3 digits) - _____

Amex Sec Code (4 digits) - _____

Patient Name _____

Patient Signature _____ _____

Date