

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ E-mail Address: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

It is okay to leave a message regarding my account and appointments Yes No

Interested in hearing about Botox Teeth Whitening

Patient is:

Policy Holder Responsible Party

Responsible Party (if someone other than yourself):

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____

Primary Insurance Information:

Name of Insured: _____ Relationship of Insured Self Spouse Child Other

Insured Soc. Sec: _____ Insured DOB: _____ Ins. Company: _____

Employer: _____ Group #: _____

Address: _____

City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship of Insured Self Spouse Child Other

Insured Soc. Sec: _____ Insured DOB: _____ Ins. Company: _____

Employer: _____ Group #: _____

Address: _____

City, State, Zip: _____

Referral Information:

Whom may we thank for referring you to our practice?

Another Patient: _____

Friend or Relative; _____

Insurance Internet Newspaper School Work Other

To the best of my knowledge, all of the answers and information provided are true and correct. If I have any changes in my insurance or personal information, I will inform the office of those changes at my following appointment without fail.

Signature of Patient, Parent or Guardian: _____

Medical History

Patients Name: _____ Birth Date: _____

Health Problems that you may have or medications that you may be taking could have an important relationship with the dentistry you will be receiving. Thank you for answering following questions.

In the past 12 months, have you been hospitalized or had a major operation? Yes No If yes, please explain: _____
 Are you taking any medications? Yes No If yes, please explain: _____
 Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonate? Yes No If yes, please explain: _____
 Are you on a special diet? Yes no
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No
 Women: Are you pregnant or trying to get pregnant? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drug
 Other If yes, please explain: _____

Do you have, or have had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you had any serious illnesses not listed above? Yes No

Comments:

To the best of my knowledge, all of the answers and information provided are true and correct. If I have any changes in my health in the future, I will inform the office of those changes at my following appointment without fail.

Signature of Patient, Parent or Guardian: _____

Patient Name: _____ Date of Birth: _____

Please read and initial each of the statements that follow:

_____ **Financial Responsibility:** I understand that I am financially responsible for all charges whether or not they are covered by insurance. Payment is due at the time of service. As a condition of your treatment by this office, financial arrangements must be made in advance prior to treatment. The patient is responsible for any unpaid balances remaining after insurance payments. Cash, check or credit card may be used to make payments on accounts. A service charge of 1.5% per month on unpaid balances will be charged on all accounts exceeding 60 days, all accounts exceeding 90 days will be turned over to a collections agency, unless prior arrangements have been made.

_____ **Patient Portion and Insurance:** I understand that any patient portion collected at the time of service is an ESTIMATE. I understand that the fee estimated listed for dental care can only be extended for a period of six months time from the date of patient's examination. I also understand that all patient portions will be due at the time of service and will be collected before being seen by the doctor. Furthermore I understand that it is my responsible to find out if my insurance is in or out of network with L.A.N.U. Dental.

_____ **Appointment Deposit:** L.A.N.U. Dental reserves the right to collect a deposit on all procedures scheduled for 1 or more hours. This amount will be determined based on the specific treatment. This amount will be applied towards the full amount due at the time of service.

_____ **Cancellations and No-Show Policy:** It is L.A.N.U. Dental policy to optimize the time our doctor and dental staff spend with each patient, this is intended to give every patient a personalized dental visit. Therefore, each patient's appointment is reserved for the appropriate time needed for each patient, as a courtesy L.A.N.U. Dental will attempt to contact each patient one day prior to their reserved appointment. If a patient does not give a 48 hour notice of cancelation L.A.N.U. dental reserves the right to charge a Cancelation/No-Show fee of \$25.00 a hour for each appointment missed without a 48 hour notice. If a patient "no-shows" 2 or more times L.A.N.U. Dental reserves the right to collect a non-refundable deposit to secure the patients next visits.

_____ **Email Correspondence:** I agree to allow L.A.N.U. Dental to correspond with me/my family by email. This includes appointment reminders and other correspondence. Listing or not listing my email on my pt paperwork shows that I allow or do not allow this type of correspondence.

_____ **Authorization to Release:** I, the undersigned, hereby authorize L.A.N.U. Dental to release information regarding my care to any referring providers/specialist. This includes necessary transfers of information/x-rays by email or electronic transfer complying with all HIPPA regulations.

_____ **Amalgam Downgrade:** I understand that my insurance may determine that they will pay for a less costly service than the covered service provided by the dentist. For example, Composite fillings and porcelain crowns may be "downgraded" to amalgam fillings or full gold crown benefits if your insurance plan pays the benefits based upon a less costly service. This may be cause even if the service provided is with an in-network dentist. I understand I am financially responsible for any difference in price from any insurance downgrades.

_____ **X-Ray Policy:** Dental x-rays are necessary for accurate diagnosis of many dental conditions; they allow the doctor to detect decay and disease of the mouth, bone, face, and jaw that may not be visible during oral examination. I understand that my insurance company may only cover a certain amount of x-rays a year. I also understand that the dentist orders x-rays based on diagnostic need and not based on insurance coverage. I understand that I will be financially responsible for any cost of x-rays that are not cover by insurance.

Signature of Patient, Parent or Guardian: _____ Date: _____

HIPPA Related Form

Patients Name: _____ Date of Birth: _____

Acknowledgement of Receipt of Privacy Policy

I have reviewed the L.A.N.U. Dental Notice of Privacy Policy, which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document per my request.

Signature of Patient: _____ Date: _____

HIPPA Authorization for Disclosure of Confidential Information

This authorizes L.A.N.U. Dental to provide and discuss any information regarding my treatment or account information to the following:

First Name	Last Name	Relationship to Patient	Date of Birth
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First Name	Last Name	Relationship to Patient	Date of Birth
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First Name	Last Name	Relationship to Patient	Date of Birth
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I do not wish to share my dental information with anyone at this time.

I agree that a photo copy of this authorization may be considered valid

Signature of Patient, Parent or Guardian	Date
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