Lavelle Family & Cosmetic Dentistry

Patient Name: ____________________

1 HEALTH HISTORY

Primary Physician's Name ____________________ **Phone#** ______________ **Date of last physical** __________

Do you have or have had any of the following?

AIDS/HIV	❑Yes	Heart Murmur	❑Yes	Tuberculosis	❑Yes
ANEMIA	❑Yes	Heart Problems	❑Yes	Tumor or growth on head/neck	❑Yes
Arthritis, Rheumatism	❑Yes	Hepatitis Type ______	❑Yes	Ulcer	❑Yes
Artificial Heart Valves	❑Yes	High Blood Pressure	❑Yes	Headaches	❑Yes
Artificial Joints	❑Yes	Kidney Disease	❑Yes	Jaw Pain	❑Yes
Asthma	❑Yes	Liver Disease	❑Yes	Jaw Popping	❑Yes
Bleeding abnormally	❑Yes	Mitral Valve Prolapse	❑Yes	Limited Opening	❑Yes
Blood Disease	❑Yes	Nervous Problems	❑Yes	Congested Ears	❑Yes
Cancer	❑Yes	Pacemaker	❑Yes	Dizziness	❑Yes
Chemotherapy	❑Yes	Psychiatric Care	❑Yes	Ringing Ears	❑Yes
Circulatory Problems	❑Yes	Radiation Treatment	❑Yes	Posture Problems	❑Yes
Heart Lesions	❑Yes	Rheumatic Fever	❑Yes	Clenching	❑Yes
Cortisone Treatments	❑Yes	Scarlet Fever	❑Yes	Grinding	❑Yes
Cough, persistent	❑Yes	Sinus Trouble	❑Yes	Facial Pain	❑Yes
Diabetes	❑Yes	Stroke	❑Yes	Neck Ache	❑Yes
Epilepsy	❑Yes	Swollen Feet or Ankles	❑Yes	Bell's palsy	❑Yes
Fainting or dizziness	❑Yes	Swollen Neck Glands	❑Yes		
Glaucoma	❑Yes	Thyroid Problems	❑Yes		
		Tonsillitis	❑Yes		

Do you use tobacco products?
❑Yes ❑No If yes, what and how often, how long
____

Do you use antidepressants or sleeping pills?
❑Yes ❑No if yes, list name(s)
____

Do you or your Spouse have the following?

Sleep Apnea ❑Yes ❑No Do you Snore ❑Yes ❑No

Have you had sleep studies ❑Yes ❑No

(C Pap) ❑Yes ❑No Do you use your CPAP ❑Yes ❑No

Are you on any blood thinners, including aspirin?
Name ____________________ mg __________

Have you ever seen an ENT (ear, nose and throat doctor)?
❑Yes ❑No Name: ____________________

Have you seen a chiropractor?
❑Yes ❑No Name: ____________________

Have you seen a neurologist?
❑Yes ❑No Name: ____________________

Have you had braces?
❑Yes ❑No Name: ____________________

Are you pregnant? ❑Yes ❑No
No If yes when is your due date? ____________________
Taking birth control pills? ❑Yes ❑No

Are you taking hormones? ❑Yes ❑No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis ____________________

____

____

❑Vitamins/Minerals ❑Herbs

Pharmacy ______________ **Phone #** __________

ALLERGIES

❑ Aspirin
❑ Barbiturates (sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ None
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other_____

2 DENTAL INTERVIEW

Our office is like no other dental office. This could be the most important dental visit you will ever have. We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability.......thank you!

- What is the main purpose of your first visit and what would you like to get accomplished? ____________________
____
- Briefly mention any positive or negative aspects of your previous dental visits: ____________________
____
- What do you already know about our office and what are your expectations? ____________________
____

Treatment Recommendations or **Treatment Options?**

Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.

The following questions help us determine what is important to you...... please rate on the following scale from 10 to 1.

1. How (dental) healthy would you like to be?

←---→
10 (healthiest) 1(not a concern at this time)

2. Almost all dental problems are predictable and preventable....in order to not overwhelm you with excess details, How preventive (or proactive) would you like to be regarding dental disease?

←---→
10 ("nip it in the bud early") 1(wait until it hurts)

3. How important are dental cosmetics to you?

←---→
10 (very important) 1(not important)

Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.
How important is facial cosmetics to you?

←---→
10 (very important) 1(not important)

Anything else you would like to mention? ____

3 NEW PATIENT MENU OF SERVICES

Our office offers a diverse array of dental services. To help us better understand your needs and desires please check which of the following services in which you are interested.

Cosmetic Services

- ❑ Smile Makeover
- ❑ Porcelain Veneers
- ❑ Full Mouth Rejuvenation

- ❑ Replacing Old Fillings
- ❑ Cosmetic Dentures
- ❑ Teeth Whitening

Discomfort / Pain

- ❑ Tooth Pain Relief
- ❑ Jaw Pain Relief
- ❑ Chronic Headache Treatment
- ❑ Migraine Treatment

Specialized Services

- ❑ Sedation Dentistry
- ❑ Dental Implant

Examination Services

- ❑ Comprehensive Examination
- ❑ Personalized Lifetime Dental Plan
- ❑ Teeth Cleaning & Maintenance

Consultative Services

Consultation about: ______________________________

2nd Opinion about: ______________________________

4 PATIENT INFORMATION

Date ______________________________

Patient Name ______________________________

Wished to be called ______________________________

Social Security # ______________________________

Address ______________________________

City ______________ State ______ Zip ______________

Sex ❑ M ❑ F Birth date ______________ Age __________

❑ Married ❑ Widowed ❑ Single

Employer ______________________________

Occupation ______________________________

Employer Address ______________________________

____

Employer Phone ______________________________

Spouse's Name ______________________________

How did you hear about our office?

____

5 INSURANCE INFORMATION

Subscriber's Name ______________________________

Subscriber's Birth Date ______________________________

Subscriber's ID or SSN ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

Is there any additional dental insurance? ______________

Subscriber's Name ______________________________

Subscriber's Birth Date ______________________________

Subscriber's ID or SSN ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

Is Patient covered by medical insurance? ______________

Subscriber's Name ______________________________

Subscriber's Birth Date ______________________________

Subscriber's ID or SSN ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

ASSIGNMENT AND RELEASE

Lavelle Family & Cosmetic Dentistry

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent, Guardian or Personal Representative

______________ Date

______________ Relationship to Patient

6 CONTACT INFORMATION

Home (   ) ______________________

Work (   ) ______________________

Cell Phone (   ) ______________________
Used for confirming appointments

E-mail Address ______________________
Used for confirming appointments

IN CASE OF AN EMERGENCY

Name ______________________________ Relationship ______________________________

Home (   ) ______________ Work Phone (   ) ______________ Cell Phone (   ) ______________

7 CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________ Email: ______________________

Address: ______________________ SSN: ______________________

____

Telephone: ______________________

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Lavelle Family & Cosmetic Dentistry

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature: ______________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the patient complete the following:

Personal Representative's Name: ______________________

Relationship to Patient: ______________________

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________ Date: ______________

Lavelle Family & Cosmetic Dentistry

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance company arbitrary determination of usual and customary rates.

Signature: I certify that I, ____, (or my dependent) have dental insurance coverage and assign directly to **Lavelle Family & Cosmetic Dentistry** all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. Patients without dental insurance coverage understand that they are responsible for 100% of the fees on or before the day of treatment.

Payment: Pre-payment is required for all prescribed/accepted dental treatment over $1000.00. Collecting in advance allows our office to reserve your time with the doctor. When you prepay for treatment you are agreeing to take care of your dental needs. Money that you prepay/pay for needed dental treatment is generally non-refundable. However, if circumstances change and you are refusing treatment and insist on a refund, there will be a 20% deduction of your pre-payment amount as well as the necessary cancellation fee. We have several payment methods we offer to our patients to assist them in taking care of their dental needs. If you use one of our finance companies and decide to change the terms of your account, you will be responsible for all charges incurred. A $25.00 fee will be applied for any returned checks.

Initial________________

Billing Policy: As a courtesy, we will bill your insurance company for services that your policy will cover in order for you to meet your insurance maximums for the year. Once payment is received from the insurance company, you will receive ONE patient statement for the balance due. It is expected that your payment will be made within fifteen (15) days. If your payment is not received, it will be considered past due. There will be a service charge of 2.75% per month on the unpaid balance of any outstanding accounts exceeding thirty (30) days, unless previously written financial arrangements have been made; provided, however, that the total rate charged on any unpaid balance shall not exceed the maximum rate allowed by law and if such increased rate exceeds the maximum amount permitted under applicable law in such circumstances, the rate shall be such maximum amount as legally may be allowed, and **Lavelle Family & Cosmetic Dentistry, PLLC's** entitlement to such sum shall be in addition to, and not in lieu of, all other rights and remedies available to it as a result of such overdue payment.

Initial________________

Unpaid Insurance Benefits: If an insurance company has not paid a claim after sixty (60) days of it being submitted, the office will require that the patient pay the account in full. This office will help prepare the patient's insurance forms or assist in making collection forms insurance companies and will credit any such collection to the patient's account. **However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.**

Initial________________

Treatment Estimates: This office routinely provides our patients with an estimate of cost for the prescribed treatment. Since your insurance determines the benefits payable for service the office cannot be held responsible for 100% accuracy on any estimate for treatment.

Initial________________

Alternate Benefits: I understand that most insurance companies downgrade coverage on non-metal restorations. I agree to the adjusted fees for the upgraded materials.

Initial________________

Condition of Treatment: As a condition of treatment by this office, financial arrangements must be made in advance, and financial responsibility (whether insurance remittance or patient portion) is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are performed.

Initial________________

Missed or Broken Appointments: Rescheduling an appointment may be done up to 48 hours prior to your scheduled appointment without expense. If there is not a 24-hour cancellation notice for an appointment, you will be assessed a $75.00/hour fee. The practice reserves the right to dismiss any patient due to repeated scheduling or missed appointments.

Initial________________

Accepted Forms of Payment: We accept the following forms of payment: cash, check, Visa, MasterCard, Discover and American Express. In addition, we offer Care Credit Financing, a patient program offering a full range of no interest and extended payment plans. We also have 5% discount for those patients that do not have dental insurance and pay in full at time of services with cash or check. If a patient would like to follow through with prescribed or elective dental care, we offer a prepayment plan and details of this plan can be discussed if interested.

Initial________________

We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. **Lavelle Family & Cosmetic Dentistry** reserves the right to update this office policy at any time without notification. My signature verifies that I have read, understand and accept the policies described above, and further grant you or your assignee permission to telephone me at home, on my mobile phone or at my work to discuss matters related to this form.

Signature____ Date________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective or all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provides performance conducting training programs, accreditation certification licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except to those described in this notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member or your personal representative or another person responsible for your care of your location your general condition or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up, filled prescriptions medical supplies, x-rays or other similar forms of heath information.

Marketing Health–Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstance.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions you may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address as the end of this Notice. If you request copies, we will charge you $5.00 for each page per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you If you request an alternative formal we will charge a cost based fee for providing your health information in that format if you prefer we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment payment healthcare operations and certain other activities for the last 6 years but not before January 1, 2006. If you request this accounting more than once in a 12 month period we may charge you a reasonable cost based fee for responding to these additional request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended) we may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. department of Health and Human Services.