Cosmetic & Implant Dentistry of Lakeland

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Lakeland, FL 33809
Office: 863-859-7630
caidoflakeland@gmail.com
www.lakelandfldentist.com

Whom do we have the pleasure to thank for referring you?

1. Google ☐

2. Insurance Company ☐

3. Internet ☐

4.Friend/Family ☐

5. Other ☐

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

ADI Number

Referral Source

Emergency Contact

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 10:03 AM | Cosmetic And Implant Dentistry LLC | Date 1/19/2018

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

			If yes
Are you under a physician's care now?	☐ Yes	☐ No	
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	
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/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Cosmetic & Implant Dentistry of Lakeland

FINANCIAL POLICY

Thank you for choosing Cosmetic and Implant Dentistry as your dental health care provider. We are committed to providing you with the most comprehensive dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment and this financial agreement is intended to facilitate our ability to provide excellent service to you.

Payment is due prior to the service provided. Our office accepts cash, Visa, and MasterCard and debit card with Visa/MasterCard logo. Financing is also available through Care Credit and Lending Club upon approval.

We must emphasize that **our service is to you, our patient**, **not your insurance company.** Deductibles, co-insurances and /or co-payments are expected at the time of service. All charges you incur are **your responsibility** regardless of your insurance coverage. As a ***courtesy,*** Cosmetic and Implant Dentistry will file on your behalf to your insurance company. Please understand that we will provide an insurance coverage estimate to you, however, this estimate is **NOT** a guarantee that your insurance will pay exactly as estimated. The Treatment Plan estimate is valid for 90 days from the proposed date. Your co-payment amount may possibly be adjusted upon the final insurance payment. Your insurance company ultimately determines how much the insurance pays and how much you pay. If you are issued a credit on your account after all payments have been received, It is the your responsibility to request a refund before 90 days or the refund will no longer be available as a credit to your account.

As a **courtesy** to you, we will **HELP** you process insurance claims, but please remember, your dental insurance plan is a contract between you, your employer, and your dental insurance company. Our office is **NOT** a party to that contract. If payment from your insurance company is not received within 30 days, you will be expected to pay balance in full.

We ask that you inform us immediately with any changes in your insurance coverage. Failure to do so may result in the inability of our office to file your claim, and thus you will be responsible for payment in full regardless of your insurance situation.

A **non-refundable $200.00 deposit** will be collected to schedule procedure appointments and payment will go towards treatment. Patients who do not cancel or reschedule their appointment 48 business hours prior to the time of the appointment will lose their deposit.

Balances older than 30 days will **BE PENALIZED $35.00 EVERY 30 DAYS**. If your account becomes past due, we will take the necessary steps to collect this debt. In the case it becomes necessary for our office to enlist the services of a collection service or litigation or report you to the Federal Credit Bureau; you will be responsible for any collection/court cost or attorney fees associated with such outstanding balances.

I HAVE READ, UNDERSTAND, HAVE HAD ALL MY QUESTIONS ANSWERED ABOUT THE FINANACIAL AGREEMENT AND ACCEPT THE FINANCIAL POLICY OF Cosmetic & Implant Dentistry of Lakeland.

Name of patient or responsible party:_____ Date:_____

Signature:_____

Cosmetic & Implant Dentistry of Lakeland

Informed Consent and Release for Three Dimensional X-Ray (iCat)

At Cosmetic and Implant Dentistry, we strive to offer our patients the highest technology when diagnosing treatment for your dental care. This may require the acquisition of a three dimensional x-ray to better view the dental area that requires diagnosis. If Cosmetic and Implant Dentistry requires one of these x-rays, it will be discussed with you during the time of your exam.

I, _____, authorize Cosmetic and Implant Dentistry, and any associates to perform the acquisition of a three-dimensional x-ray (also known as tomogram, CT scan, CBCT or iCAT) for the purpose of evaluation, diagnosing, and documentation of my treatment.

☐ I would like the three-dimensional x-ray reviewed by an expert dental radiologist and I will be responsible for the fees incurred.

☐ I waive the right to have the three-dimensional x-ray read by a dental radiologist expert. If for any reason there is pathology or any other abnormal radiographic findings that is not identified by a non-expert dental radiologist (hence, Cosmetic and Implant Dentistry and associates), then I release them of any responsibility.

_____ _____
Patient or Guardian Signature Date

_____
Witness

Informed Consent and Release for Photographic Pictures

During your treatment at Cosmetic and Implant Dentistry, staff may take photos for treatment documentation.

I, _____, authorize Cosmetic and Implant Dentistry, and any associates to perform the acquisition of photographic pictures for the documentation of my treatment.

_____ _____
Patient or Guardian Signature Date

_____
Witness

Cosmetic & Implant Dentistry of Lakeland

Patient Acknowledgement of Notice of Privacy Practices

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care options.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

My diagnosis, treatment, and medications may be discussed with?

Name and relationship:_________ Date:

Patient Signature:_____

Patient's Name Printed Out:_____

Cosmetic & Implant Dentistry of Lakeland

AUTHORIZATION TO OBTAIN AND THE RELEASE OF INFORMATION & CONSENT TO RECEIVE, MAIL, OR TELEPHONE MESSAGES

I hereby authorize Cosmetic and Implant Dentistry to release any/all of my medical/dental information for the purpose of:

- Any request from my insurance company
- Any Dentist, Physician, or Specialist I am referred to (General Dentist, Endodontist, Periodontist, Oral Surgeon)

I understand that the information that may be released may include confidential medical/dental information that was provided by me. I hereby release Cosmetic and Implant Dentistry from all legal responsibility or liability that may arise from the action I have authorized above. I also give consent to receive mail or telephone messages from Cosmetic and Implant Dentistry.

PATIENT NAME: Date:

SIGNATURE: