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 doctor 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 interrelationship 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
Do you snore or have you been diagnosed with sleep apnea? ☐ Yes ☐ No
Do you wear a CPAP? ☐ Yes ☐ No
Have you ever had a sleep test? ☐ Yes ☐ No
Are you sleepy or tired during the day? ☐ Yes ☐ No
Have you had your tonsils surgically removed? ☐ 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 ◯ 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 Problem ◯ 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 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 doctor 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 cancellation L.A.N.U. dental reserves the right to charge a Cancellation/No-Show fee of $25.00 an 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 HIPAA 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: _____

HIPAA 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: _____

HIPAA 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

☐ 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