LEE DENTAL CENTERS

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PATIENT REGISTRATION

We welcome you as a new patient and appreciate the opportunity to provide you with complete professional dental services. Please help us by completing all the information requested below. Thank you!

PLEASE PRINT

PATIENT INFORMATION:

Last Name:_____ First Name:_____ MI_____

Street Address:_____ City:_____ State:_____ Zip: _____

Code:_____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Date of Birth: _____/_____/_____ SS#:_____-_____-_____ Email:_____

Employer:_____ If Patient is a Student, Name of School:_____

Emergency Contact:_____ Relationship:_____ Phone: (_____) _____-_____

REFERRAL SOURCE (CHECK ONE):

☐ Insurance ☐ Billboard / Drive By ☐ Internet ☐ Website ☐ Mailer / Magazine

Patient:_____ Other Doctor/Office:_____

RESPONSIBLE PARTY INFORMATION:

Last Name:_____ First Name:_____ MI:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Date Of Birth: _____/_____/_____ SS#: _____-_____-_____ Email:_____

Employer:_____ How Long Employed?:_____

Spouse's Name:_____ Spouse's Employer:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____ _____

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ Others (Please Specify):_____

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PATIENT PERSONAL INFORMATION

Last, First _____ Account Number _____

Birth Date _____ Email _____

PATIENT MEDICAL INFORMATION

Allergic To:

- ☐ Amoxicillin
- ☐ Penicillin
- ☐ Tetracycline / Minocycline
- ☐ Clindamycin
- ☐ Aspirin
- ☐ Barbiturates / Sleeping Pills
- ☐ Codeine / Other Narcotics
- ☐ Latex Rubber
- ☐ Local Anesthetics/Epinephrine
- ☐ Metals
- ☐ Sulfa Drugs

Check, if Applicable:

- ☐ AIDS
- ☐ HIV Infection
- ☐ Acid Reflux
- ☐ Alcohol / Drug Abuse
- ☐ Alzheimers / Dementia
- ☐ Anemia
- ☐ Anorexia / Bulimia
- ☐ Anxiety
- ☐ Arthritis – Osteoarthritis
- ☐ Arthritis – Rheumatoid
- ☐ Asthma / Hay Fever
- ☐ Autoimmune Disease
- ☐ Bipolar
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer / Tumor or Growth
- ☐ Cardiovascular Disease
- ☐ Angina
- ☐ Damaged Heart Valve
- ☐ Heart Valve Replacement
- ☐ Rheumatic Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Mental Health Problems
- ☐ Chest Pain Upon Exertion
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells / Seizures
- ☐ Fever Blisters / Cold Sores
- ☐ Fibromyalgia
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Joint Replacement
- ☐ Kidney / Bladder Trouble
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lupus
- ☐ Neurological Disorder
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Premedicate – Dental Treatment
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sleep Apnea / Sleep Disorder
- ☐ Swollen Glands
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Unusual Weight Loss
- ☐ Urinate Frequently
- ☐ Sjogren's Syndrome

MEDICAL QUESTIONNAIRE

Have you had any serious illness, operation or hospitalization within the past 5 years? ☐ Yes ☐ No

If Yes, what illness or problem? _____

Are you currently taking any medication, prescription and/or over the counter? ☐ Yes ☐ No

If Yes, please list? _____

Are you an alcoholic / recovering alcoholic? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Has a physician or dentist ever recommended you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Women Only

Are you pregnant? ☐ Yes ☐ No

If Yes, what is your due date? _____

Are you currently nursing? ☐ Yes ☐ No

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

PLEASE TURN OVER

DENTAL QUESTIONNAIRE

Date of your last cleaning _____

Last exam date _____

Date of your last x-rays _____

Any difficulties with previous dental treatment? ☐ Yes ☐ No

If yes, please list _____

Are you currently having any dental problems? ☐ Yes ☐ No

If yes, please list _____

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

Have you ever been told you have periodontal (gum) disease? ☐ Yes ☐ No

Have you had any periodontal treatment (deep cleaning/surgery)? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold or sweets? ☐ Yes ☐ No

Do you chew/smoke tobacco in any form? ☐ Yes ☐ No

If yes, what is the quantity and duration of use? _____

Have you had any head, neck or jaw injuries? ☐ Yes ☐ No

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you snore or have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Would you like your teeth straightened? ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No

Would you like your teeth whiter? ☐ Yes ☐ No

If you could change anything about your smile, what would it be? _____

Additional Comments from Patient _____

_____

Additional Comments from Provider _____

_____

NOTE: Both Doctor and patient are encouraged to discuss any or all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Lee Dental Centers, Dentist(s), or any other employee(s) or agent(s) of Lee Dental Centers responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify my Dentist and Lee Dental Centers of any change in my health.

Patient/Guardian Signature _____ Date _____

Provider Signature _____ Date _____

LEE DENTAL CENTERS

FINANCIAL POLICY

Payment for service is kindly requested **at the time of scheduling**. For your convenience, we accept cash, check, Visa, MasterCard, American Express and Discover. In addition, we offer a 4-month payment plan, and no interest and extended payment plans through Compassionate Finance and Care Credit. Our receptionist will be happy to assist you with this process.

We ask that you understand the following about dental insurance:

- Your insurance policy is a contract between you, your insurance provider, and/or your employer. We are not a party to that contract. We cannot become involved in disputes between you and your insurer regarding deductibles, covered fees, co-payments, secondary insurance, and usual and customary charges. However, we are contracted with certain preferred provider plans (PPO), managed care plans (HMO), and discount plans. We will follow the guidelines for patient care, reimbursement and submission of claims for services rendered.

- We do our best to **estimate** what your insurance will cover on recommended procedures. Your insurance company is promptly billed following your procedures and most insurance companies respond within four to six weeks. You will receive a monthly statement from our office reflecting your account status. Once insurance has paid their portion, you are responsible for any remaining balance on the account at that time. We kindly ask that you remit additional payments promptly. Should financial arrangements be necessary, please contact our billing office at (210) 681-7001.

- Any unpaid balances older than 90 days or returned checks older than 30 days may be subject to collection placement and collection fees.

- To allow us to best serve you, please notify us of any changes to your insurance and keep us updated on your current phone number and address.

For insurance claims: You agree to authorize the release of any information relating to the claim. You also authorize payment directly to Lee Dental Centers of the insurance benefits otherwise payable to you. You are responsible for any balance on this account that may arise from amounts not covered by insurance.

If you must cancel or reschedule your appointment, all cancellations must be made at least 24 hours in advance. If you fail to give 24 hours notice, a cancellation fee may apply.

Thank you for choosing Lee Dental Centers as your provider. We are grateful for the opportunity to serve you and your family.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Print Name: _____

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_____

_____

_____