

ID CHECKED (RESPONSIBLE PARTY)



INFORMAION (CHILD UNDER 18)

Name _____ Preferred Name _____ Sex _____

Home Address _____

Home Phone _____ Age _____ Date of Birth _____

School _____ Grade _____

How did you hear about us? _____

What is the name/phone number of the child's previous dental office?

With whom would you like the appointments confirmed?				
Mother		Father		
How would you like us to confirm the appointments? (Please select ONE of the following)				
Text Message	Email	Home Phone	Cell Phone	Work Phone

FATHER'S INFORMATION					
Is this person responsible for the account?		Yes	No		
Last Name			First Name		
Address			Date of Birth		
City		State		Zip	
Driver License #			SSN		
Employer			Occupation		
Email Address					
Home Phone					
Work Phone					
Cell Phone					
Marital Status:					
Single	Married	Separated	Divorced	Widowed	Remarried

MOTHER'S INFORMATION					
Is this person responsible for the account?		Yes	No		
Last Name				First Name	
Address				Date of Birth	
City		State		Zip	
Driver License #		SSN			
Employer		Occupation			
Email Address					
Home Phone					
Work Phone					
Cell Phone					
Marital Status:					
Single	Married	Separated	Divorced	Widowed	Remarried

EMERGENCY CONTACT:

Name _____ Relationship _____

Home Address _____ Home Phone _____

Dental Insurance: PRIMARY			
Insurance Company		Phone #	
Group/Policy #		SS#	
Employer	Insured's Name		
Member ID#	Date of Birth		

Dental Insurance: SECONDARY			
Insurance Company		Phone #	
Group/Policy #		SS#	
Employer	Insured's Name		
Member ID#	Date of Birth		

Does the patient have any of the following habits?					
Clenching	Finger Sucking	Lip Biting	Nail Biting	Gum Chewing	Ice Chewing

MEDICAL HISTORY

YES	NO	
		Do any of the patient's teeth hurt? If yes, how long?
		Are any of the patient's teeth sensitive to sweets or cold? If yes, how long does the sensation last?
		Have there been any injuries to the patient's mouth or teeth? If yes, describe
		Has the patient ever had any injury to the head and neck area? If yes, describe
		Has the patient ever fallen and bumped their chin, or received a blow to the jaws? If yes, describe
		Has the patient ever had any surgery in the head and neck area? If yes, describe
		Has the patient ever had complications or illness following dental treatment? If yes, when
		Has the patient ever been told they have periodontal disease (gum disease)? If yes, describe
		Does it hurt to chew? If yes, where does it hurt?
		Does the patient hear clicking, popping, or grating sounds in the jaw joints? If yes, describe
		Has the patient ever been required to take antibiotics before visiting the dentist? If yes, why?
		Does the patient drink bottled water?

I have reviewed the above medical and dental information, and find it accurate. If there are any later changes in my clinical history, I understand that it is my responsibility to inform Dr. Flannagan. I also give permission for Dr. Flannagan to perform a clinical examination and to make recommendations for treatment. *******I have chosen the dental provider: Dr. Flannagan, Lasting Impressions Family Dental Care of my own free will.**

X _____ (please initial)

I certify that I am covered by _____ insurance company and I assign directly to Lasting Impressions Family Dental Care all insurance benefits otherwise payable to me.

I understand I am responsible for payment of services rendered and also responsible for paying any fees, co-payment and deductible that my insurance does not cover. I also agree to pay interest at the rate of 18% APR on any balance over 90 days from the date of service. I further agree to pay any collection fees, attorney fees, and court cost should these means of collection become required. **I understand I am responsible for any collection agency fees and/or a fee for missed appointments if sufficient notice is not given. If we have not received sufficient notice, a charge may be applied to your account.** The undersigned allows Lasting Impressions Family Dental Care to use patient photos (withholding all names) as educational tools within our practice. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I acknowledge that I have received a copy of Dr. Flannagan's "Notice of Privacy Act" –HIPPA Act and Dr. Flannagan's Office Policy.

X _____

Date: _____

COMMUNICATION CONSENT:

Please list the individuals with whom we may discuss medical/financial information and indicate if we may leave a voicemail on that number with medical/financial information:

Name	Relationship	Phone Number (with area code)	Yes, leave a voicemail
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

I authorize Lasting Impressions Family Dental Care to leave medical and account information pertaining to this patient's care on the voicemail for the phone numbers listed above. I also assume responsibility to notify Lasting Impressions Family Dental Care whenever this information changes. In addition to medical information, I authorize information concerning appointment confirmation, rescheduling, or staff follow up be left.

X _____ Date: _____

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.

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Do you use tobacco? (What and How Much?) Do you use controlled substances?

Women: Are you...

Pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other allergy? Yes No If yes

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

AIDS/HIV Positive Alzheimer's Disease Drug Addiction Rheumatic Fever Rheumatism Scarlet Fever Artificial Joint Asthma Blood Disease Blood Transfusion Frequent Headaches Low Blood Pressure Thyroid Disease Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Heart Trouble/Disease Anxiety Cortisone Medicine Diabetes Hepatitis B or C Angina Arthritis/Gout Artificial Heart Valve Excessive Thirst Fainting Spells/Dizziness Frequent Cough Leukemia Liver Disease Swelling of Limbs Chemotherapy Heart Attack/Failure Heart Murmur Heart Pacemaker Psychiatric Care Depression Hemophilia Hepatitis A Renal Dialysis Emphysema Epilepsy or Seizures Excessive Bleeding Hypoglycemia Irregular Heartbeat Kidney Problems Stomach/Intestinal Disease Stroke Cancer Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Yellow Jaundice Seasonal Allergies Radiation Treatments Anaphylaxis Anemia High Blood Pressure High Cholesterol Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Breathing Problems Bruise Easily Glaucoma Tonsillitis Tuberculosis Tumors or Growths Ulcers ADHD

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

Comments:

Empty text box for 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: _____

OFFICE POLICY AND FINANCIAL AGREEMENT

For the convenience of our patients, the following office policy and financial agreement has been established for your review.

Cash / Check / Credit Card

Lasting Impressions Family Dental Care gladly accepts cash, check, or credit card payments.

Credit Cards

We accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. We offer these to allow you the most convenience in taking care of your account.

Dental Insurance

As a service to our patients, we will file your dental insurance via electronic claims. We work with your insurance company to provide the most accurate estimate of your co-pays. It is the patient's responsibility to provide the correct insurance information at the first visit. Payment in full is required at the time of service for all non-insured patients. Insured patients are responsible for, and should be prepared to pay all amounts not to be covered by the insurance estimate. With insurance plans paying only a portion of treatment cost, we can only estimate what your insurance company will pay. The maximum time allowed for an insurance payment is sixty days. After sixty days, the patient is responsible for the entire balance.

Payment Plans

We have made arrangements with the Care Credit Company to provide payment plans. This allows you to complete your dental work without delay and make relatively small monthly payments. Care credit is used for treatment over \$300. Applications are available and approval can be determined within ten minutes. For your convenience you can also apply online at www.carecredit.com

We also offer a financial option that requires a down payment followed by monthly payments automatically withdrawn from a bank account. Please ask about this option that can be tailored for your specific needs.

Cancellations

As a courtesy to all patients we ask that a forty-eight hour notice be given for a cancelled appointment. **If we have not received sufficient notice, a charge may be applied to your account.**