☐ ID CHECKED

INFORMATION (ADULT)

Name ___________________________________ I prefer to be called_______________ Sex______________

Age_____ Date of Birth______________SSN#___________________ Driver Lic.#______________________

Home Address____

Home Phone______________________________ Cell Phone ________________________________

Work Phone ______________________________ Email Address _____________________________

Employer____________________________________ Occupation___________________________________

How did you hear about us?____

What is the name/phone number of your previous dental office?

How would you like us to confirm your appointments? (Please circle one of the following)				
Text Message	Email	Home Phone	Cell Phone	Work Phone

Marital Status:					
Single	Married	Separated	Divorced	Widowed	Remarried

Spouse's Name____ Date of Birth__________________________

Employer___________________________Occupation_______________Work Phone____________________

EMERGENCY CONTACT:

Name____Relationship______________________

Home Address____Phone Number___________________

Person Responsible for Account (Circle one)	Self	Other

If “OTHER” fill in this section:			
Last Name		First Name	
Address		Date of Birth	
City / State		Zip	
Driver License #		SSN #	

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

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

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 Dr. Flannagan 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
			☐
			☐
			☐

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:_______________________

Time 9:33 AM

Lasting Impressions Family Dental Care

Date 4/12/2016

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.

Question	Answer	
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco? (What and How Much?)	Yes No	If yes
Do you use controlled substances?	Yes No	

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?

Condition		Condition		Condition		Condition	
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	Anaphylaxis	Yes No
Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	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	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	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
Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No	Glaucoma	Yes No
Thyroid Disease	Yes No	Chemotherapy	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
Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Yellow Jaundice	Yes No	ADHD	Yes No
Anxiety	Yes No	Depression	Yes No	Seasonal Allergies	Yes No		

Have you ever had any serious illness not listed 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:___________

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.**