LifeSmile DENTAL GROUP

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

ABOUT YOU

Name _____

Preferred Name_____ ☐ Male ☐Female

☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate ____/____/____ Age ____SS # ____-____-_____

Address _____

City _____ State _____ Zip _____

Home # _____ Work # _____

Cell #_____

Permission to send TEXT appointment reminders?

☐ Yes ☐ No

Email_____

Other family members seen by us? _____

_____

Last visit date? _____

Employer _____ Employer Ph # _____

Employer Address _____

_____

How long employed there? _____

SPOUSE INFO

Name _____

Home # _____ Work # _____

Cell # _____ Birthdate ___/____/____

EMERGENCY CONTACT

IN THE EVENT OF AN EMERGENCY,
WHO SHOULD WE CONTACT?

Name _____ Relation _____

Phone # _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Cell # _____ Birthdate ____/____/____

Email _____

Billing Address _____

City _____ State _____ Zip _____

SS# _____

INSURANCE

Subscriber Name_____

Relation _____

Subscriberõs Birthdate _____/_____/_____

Subscriberõs Employer _____

Carrier Name _____

Phone # _____

Group # _____

ID # _____

IF YOU HAVE A SECONDARY INSURANCE
PLEASE LET A TEAM MEMBER KNOW.

How did you find us? Family/Friend Drive-by Mailer
Insurance Plan Web Search Website Other _____

Name of person, office or other referring you to this office _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

MEDICAL HISTORY

Are you currently under the care of a physician?
Please explain _____
Phone # _____ Last visit date_____

_____

Your current physical condition
☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No
Are you taking any prescription / over-the-counter or herbal supplement drugs? ☐ Yes ☐ No
Please list each one _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE

Aspirin	Yes	No
Codeine	Yes	No
Erythromycin	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Tetracycline	Yes	No
Jewelry./Metals	Yes	No
Latex	Yes	No
Anesthetics	Yes	No
Other	Yes	No

Please list any other drugs/materials that you are allergic to:

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal Bleeding	Yes	No	Hepatitis	Yes	No
Alcohol / Drug Abuse	Yes	No	Herpes / Fever Blisters	Yes	No
Anemia	Yes	No	HIV, AIDS	Yes	No
Artificial Bones, Joints, or Valves	Yes	No	Kidney Problems	Yes	No
			Liver Disease	Yes	No
Asthma	Yes	No	Low Blood Pressure	Yes	No
Blood Transfusion	Yes	No	Lupus	Yes	No
Cancer / Chemotherapy	Yes	No	Mitral Valve Prolapse	Yes	No
Colitis	Yes	No	Pacemaker	Yes	No
Congenital Heart Defect	Yes	No	Psyciatric Problems	Yes	No
Diabetes	Yes	No	Radiation Treatment	Yes	No
Difficulty Breathing	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Emphysema	Yes	No	Seizures	Yes	No
Epilepsy	Yes	No	Shingles	Yes	No
Fainting Spells	Yes	No	Sickle Cell Disease	Yes	No
Frequent Headaches	Yes	No	Sinus Problems	Yes	No
Glaucoma	Yes	No	Stroke	Yes	No
Hay Fever	Yes	No	Thyroid Problems	Yes	No
Heart Attack	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Ulcers	Yes	No
Heart Surgery	Yes	No	Venereal Disease	Yes	No
Hemophilia	Yes	No			

Please list any medical conditions that you have, or are being treated for: _____

_____

_____

_____

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week # _____
Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No
Are you currently in pain? ☐ Yes ☐ No
Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you, or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Your current dental health is ☐ Good ☐ Fair ☐ Poor
Do your gums ever bleed? ☐ Yes ☐ No
How many times a day do you brush? _____
How many times a day do you floss? _____
Type of toothbrush bristles? ☐ Hard ☐ Med ☐ Soft
Do you like your smile? ☐ Yes ☐ No

DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees and court costs.

_____
Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

LifeSmile DENTAL GROUP

LifeSmile Dental Group
Financial Agreement & Office Policies

Payment Options:

- Patient portions are due in full at the time services are rendered.
- A 5% discount is offered on all uninsured patients who pay in full at the time of service. A 10% discount is offered for Seniors 60+ who pay in full at time of service.
- We accept the following major credit cards: **VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS.**
- For those who desire a payment plan, we are partnered with a patient financing company called **CARE CREDIT.** Payment plans are based on approved credit. There are no application fees. These arrangements must be made prior to treatment.

Insurance:

As a courtesy, we do bill your dental insurance on your behalf. We ask that your estimated co-payments be paid in full at the time services are rendered. **Please be advised that some of the services we provide may not be covered services by your dental plan. You are responsible for the total fee of all services rendered regardless of your insurance company's exclusions, limitations and or any denial of dental benefit.** Any balance unpaid after 45 days will be subject to interest equal to 1.5% per month. Balances over 90 days maybe assigned to a collection agency. Any checks returned to our office for non-sufficient funds will be subject to a fee of $25.00.

Appointment Policy:

When you schedule an appointment, our office reserves this appointment time just for you. If you are late or are unable to keep your appointment, this prevents us from providing your dental needs. **Missed appointments, or appointments cancelled with less than 48 (business hours), may be assessed a $50.00 cancellation fee.** Multiple missed appointments or short-notice cancellations may result in additional fees, and after the third time may result in termination of our patient-doctor relationship, due to our office being unable to successfully care for your dental needs.

Minor Patients:

If a minor is not accompanied by their parent/guardian, arrangements for payment need to be made prior to the appointment.

I have read and understand LifeSmile Dental Group's Office Policies. I agree to pay for all services rendered in accordance with the terms and conditions set forth in the office policies stated above. I understand that, regardless of insurance coverage, I am responsible for payment of any services rendered.

Patient Receiving Treatment: _____

Responsible Party Printed Name: _____

Responsible Party Signature: _____ Date: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operation, but that you are not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name (Printed): _____

Signature: _____Date:_____

Relationship to the patient (*if signing for a minor): _____

LifeSmile Dental Group

13305 NW Cornell Rd., Suite A

Portland, OR 97229

503-644-5433