LA PERIODONTICS & IMPLANT SPECIALISTS

Patient Information

Patient Name: _____ Date: _____

Preferred Name: _____ Sex: M F SSN: _____

Title: Mr. Mrs. Ms. Mx. Dr. Family Status: Single Married Child Other

Birthdate: _____ Date of Prev. Visit: _____ E-mail: _____

Phone: _____ _____ _____ _____
Mobile Home Work Other

Address:
_____

_____
__

Employment Information

The following is for: the patient the person responsible for payment both N/A

Employer Name: _____ Phone: _____

Employer Address: _____
Address City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified?

_____
_
Name Relationship Phone Number

Primary Dental Insurance

Name of Insured:
_____
Last First MI

Insured's Birth Date: _____ ID#:_____ Group#:_____

Insured's Family Status: Married Single Child Other Insured's SSN#:_____

Insurance Plan Name:

_____

Insurance Company Phone Number: _____

Insured's Address:

_____

__

Address City State Zip Code

Insured's Phone Number: _____

Relationship to Insured: Self Spouse Child Other: _____

Secondary Dental Insurance

Name of Insured:

_____

Last First MI

Insured's Birth Date: _____ ID#:_____ Group#:_____

Insured's Family Status: Married Single Child Other Insured's SSN#:_____

Insurance Plan Name:

_____

Insurance Company Phone Number: _____

Insured's Address: _

_____

_____

Address City State Zip Code

Insured's Phone Number: _____

Relationship to Insured: Self Spouse Child Other: _____

Insurance Authorization: By signing I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

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_____ _____ _____

Printed Name **Signature** **Date**

How would you rate the condition of your mouth (please circle one):

Excellent Good Fair Poor

Previous Dentist Name and Phone Number:

_____

Name Phone Number

Date of most recent dental exam and/or x-rays:

_____

_____

I routinely see my dentist every (please circle one):

3 months 4 months 6 months 12 months Not routinely

What is your immediate concern?

_____

_____

_____

_____

Check all that apply:

- ☐ Had complications
- ☐ Had trouble getting numb

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- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you ever experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes needs further explanation, please describe:

_____
_____
_____
_____
_____

Consent for Periodontal Services

I hereby authorize and request the above named doctor and her auxiliaries to perform for me all periodontal therapy and surgery indicated in my dental records and to do whatever procedures are deemed advisable in her judgment. I will discuss any aspect of my treatment I do not understand with my periodontist. I acknowledge that the benefits and risks of periodontal therapy are understood prior to accepting treatment. I also authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the above named doctor. It has been explained to me, and I understand, that results are not, and cannot be, guaranteed or warranted. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____

Printed Name Signature Date

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made. All accounts are due and payable at time of service rendered, unless prior arrangements have been made. If it is desired to extend payments for more than 30 days, specific arrangements must be made with our office. These extended payment courtesies are made at no interest or finance charge provided payments are received as promised. To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

_____ _____ _____

Printed Name Signature Date

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 business hours in advance. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 48 business hours. There will be a fee of $75.00 assessed if we do not receive a call to cancel an appointment. If you have a surgery scheduled, we need 72 hours' notice; if not, you will forgo $300 from the initial deposit for the surgery. Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

_____ _____ _____

Printed Name Signature Date

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HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____ _____

Printed Name Signature Date

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

_____ _____ _____

Printed Name Signature Date

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