**Lakeland Family Dentistry, PC**

**Patient Information**

**Patient Name:**  **Date*:***

Last, First MI ***(Preferred Name)***

**Gender:** * Male  Female* **Marital Status:** * Married  Single  Child  Other* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security *#:*** **Birth Date**:

**Phone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(Cell):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Work):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:**

Street Apartment #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

**Personal Emai**l: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse / Parent / Legal Guardian Information**

***\*\*If patient is under 18 years old- this person will be the account guarantor. Account guarantor is responsible for payment on all services\*\****

**Name:**

Last, First MI (Preferred Name)

**Gender:** * Male  Female* **Marital Status:** * Married  Single  Divorced  Widowed  Separated*

**Relation to Patient:**  Spouse  Mother  Father  Legal Guardian  Other

*\*\*Legal Guardians must present proper paperwork showing guardianship to receptionist\*\**

**Social Security #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date:**

**Phone (Home):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Cell):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Work):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:

Street Apartment #

City State Zip Code

**Employer Name:** **Occupation:**

**Insurance Information**

*\*\*This portion requires information on the person who is the PRIMARY for the insurance\*\**

*\*\*Please give insurance card(s) and photo I.D. to receptionist\*\**

**Primary Insurance**

Insurance Provider:

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is insured a patient?  Yes  No

Last First MI

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's Employer Name:

**Secondary Insurance**

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is insured a patient?  Yes  No

Last First MI

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's Employer Name:

# Referral Information

# *Whom may we thank for referring you?*

# Patient Our Staff Dental/ Medical Office Online (Facebook, Website, Google) Yellow Pages School Insurance Company Other

If applicable, please list the name of person or office referring you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

**Have you ever had any of the following? Please check those that apply:**

|  |
| --- |
| AIDS |
| * ADHD/ ADD * Allergies |
| \*\*Please list below\*\* |
| Anemia |
| Arthritis |
| Artificial Joints  Artificial Heart Valve |
| Asthma |
| * Autism * Blood Disease |
| Cancer |
| Diabetes |
| Epilepsy *(Seizures)* |
| Excessive Bleeding |
| Hay Fever |
| Head Injuries |
| * Heart Disease * Heart Murmur |
| Hepatitis (A, B, or C) |
| High Blood Pressure |
| HIV |
| Jaundice |
| Kidney Disease |
| Liver Disease |
| Mental Disorders |
| Nervous Disorders |
| Pacemaker |
| Pregnancy |
| Due date:\_\_\_\_\_\_\_\_\_ |
| Radiation Treatment |
| Respiratory Problems |
| Rheumatic Fever |
| Sinus Problems |
| Stroke |
| Tuberculosis |
| Tumors |
| Ulcers |
| Venereal Disease |
| Codeine Allergy |
| Penicillin Allergy |
| Latex Allergy |
| Local Anesthetic Allergy |
| Sulfa Allergy |

* Do you have anxiety about dental treatment?  Yes  No
* Would you be interested in sedation for your dental treatment?  Yes  No
* Do you currently use or have you previously used any form of tobacco?  Yes  No
* Do you have a history of drug abuse?  Yes  No
* Are you currently under the care of a physician?  Yes  No
* If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you have any health and/or dental problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please list **ALL** medical allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Please list **ALL** current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Services**

*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are ever any change in my (the patients) health, I will inform your office at the next appointment without fail. I understand that signed permission must be obtained before any dental service can be rendered. I give my consent to Dr. Eric Castor and his staff to perform such treatment, services, medication, radiographs, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/ oral deficiency, abnormality, and/ or infection to the best of his abilities, regardless of insurance coverage. I understand and consent to the Patient Consent & Financial Policy, and understand that I am financially responsible for any and all services provided, to the patient listed above, by this office. I have also read and consent to the Office Policies posted in the lobby. \*\*If you would like an additional copy please ask the receptionist\*\**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Signature of patient, parent or guardian***

**POLICY CONSENT**

Please familiarize yourself with the following information regarding our office policies.

***\*\*Please initial on each line indicating you understand each statement\*\****

**FINANCIAL POLICY**

*For the convenience of all of our patients, we accept cash, personal check, Care Credit, MasterCard, VISA, & American Express. Every effort is made to calculate your patient portions for each date of service. However, they are still only estimates based on the current information we have. The exact amounts are not factually known until the claim has been paid and received. We file contracted insurance as a courtesy, however, you are responsible for any balance amount.*

\_\_\_\_\_\_ All procedures are charged and due at the time of service. If you have insurance we may file it as a courtesy to you. All ***estimated*** patient portions associated are *due at the time of service*.

\_\_\_\_\_\_ Monthly statements are mailed for remaining balances. The balance is due upon receipt of the statement. For any account with a balance extending after the time of service will be charged a monthly finance charge of 5% or $0.50, whichever is greater.

\_\_\_\_\_\_ Dental coverage is between you, your employer, and the insurance company. It is your responsibility to understand what services are covered, if you are in or out-of-network, or if you have deductibles, etc. If the estimated insurance payment is not received within 30 days from date of service, you will be expected to pay in full.

\_\_\_\_\_\_ Returned Checks / Declined drafts will be charged a non-refundable $35.00 fee for each occurrence.

\_\_\_\_\_\_ Balances not paid in full after 60 days will be subject to collections. We may instill the help of an outsourced collection agency, and/or small claims court. Once an account balance extends past 90 days, a 33% collection fee will be added to the account, plus any court fees or attorney fees associated with the pursuit of collections. Furthermore, the patient(s) on the account will be dismissed from the practice.

\_\_\_\_\_\_We will not allow new appointments to be scheduled for any patient under an account with a past due balance.

\_\_\_\_\_\_A deposit may be required in order to reserve an appointment consisting of more than 90 minutes. The deposit is equal to ½ of the estimated patient portion for that appointment.

**MISSED APPOINTMENT POLICY**

\_\_\_\_\_\_ First missed appointment will be a warning.

\_\_\_\_\_\_Second offense: You will be required to pay a non-refundable deposit before scheduling your next appointment. The deposit is equal to $50 or 50% of the expected patient portion for the appointment. If the appointment is kept, the deposit will be applied to treatment completed during the appointment or future appointments. If the appointment is missed, the deposit is forfeited.

\_\_\_\_\_\_Third missed appointment may result in office dismissal.

**APPOINTMENT CONFIRMATION POLICY**

\_\_\_\_\_\_You are responsible for providing our office with a reliable way to contact you regarding appointments.

\_\_\_\_\_\_If we are unable to obtain confirmation regarding your scheduled appointments, we reserve the right to cancel your appointment, until a confirmation is obtained.

**Policy Consent**

*I have read, and I understand all of the financial& appointment statements listed above. I understand I am financially responsible for all charges on this account on the date of service. I understand all unpaid balances will be charge a monthly finance charge, and balances remaining after 60 days are subject to collections, where I am responsible for a 33% collection fee plus any and all court and attorney fees associated.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Permission To Use Medical Information

It is our goal to always provide you with the highest standards of care. To that end, we are constantly trying to improve the results of our patients who proceed with our practice. Our ability to anonymously use some of the data we collect about you during your treatment can be extremely helpful. Tracking the results of your treatment and comparing it to the treatment of our other patients allows us to track outcomes and ultimately provide better service to you and other patients which will ultimately better our practice. We greatly appreciate your cooperation and any of your medical information used in the strictest confidentiality.

Your signature below authorizes us to use your medical information for future references, information regarding the diagnosis and work related to your treatment can be used anonymously for future outcome analysis.

HIPPA Privacy Notice

This notice describes how medical information about you may be used, disclosed, and how you can get access to the information. This notice describes the privacy practices of the doctor listed at the bottom of this form, Lakeland Family Dentistry, which is referred to as “The Provider” in this notice. The notice applies only to use and disclose medical information collected by the provider about persons residing in the United States of America or otherwise subject to the laws of the United States.

The provider may collect protected health information for use in our office information and any referral services. The information will be used and disclosed in identifying consultants, sending information to physicians or other health care providers. The providers will not remove personal identifiers (name and address) before disclosing your information to expert physicians or other health care providers. The provider also may disclose your health information to administrators or others who are involved in operating services. The provider may also disclose your health information or personal information (name and address) and health insurance information so that physicians and other health care providers can bill for medical services rendered to you, and to enable us to collect payments from physicians or other health care providers who participate in the services. We will only disclose the minimum necessary information needed to fulfill this purpose.

The provider may use or disclose information in order to contact you during the course of providing services to you as either part of the ongoing process or as part of an effort to follow up with you after using the service or if there was an opportunity to inform you about additional services that may be of interest to you. We may contact you through the mail, over e-mail, or through phone calls. The provider may disclose protected health information as required by law.

To receive another copy of this notice call (229) 482-1100 or send a written request to: Lakeland Family Dentistry 33 N Hospital Dr Lakeland, GA 31635. Providers will keep the current policy on the website ([www.lakelandfamilydentistry.com](http://www.lakelandfamilydentistry.com)) and available at the office, if for any reason you would like to discuss any matter concerning our privacy policies please contact us.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Guarantor Printed Name Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Guarantor Signature Date