PATIENT INFORMATION

Name ____

Last Name First Name Middle Initial Preferred Name

Sex ☐ M ☐ F Birthdate _______________ SS# ___________________________ ☐Single ☐Married ☐Divorced ☐Minor

Address ____________________________________City _________________ State ___________ Zip Code______________

Cell Phone __________________________ Home Phone _________________________ E-Mail ________________________

Patient Employer ____ Occupation ________________________________

Employer Address ____ Employer Phone ____________________________

Emergency Contact ____ Phone ___________________________________

Whom may we thank for referring you? ____

PRIMARY INSURANCE

Subscriber Name ____

Last Name First Name Middle Initial

Birthdate _________________ SS# ____________________________ Relation to Patient ___________________________

Employer ____ Occupation ________________________

Employers Address ____ Phone _________________________ ___

Insurance Company ________________________________Subscriber ID # ____________________ Group # _____________

SECONDARY INSURANCE

Subscriber Name ____

Last Name First Name Middle Initial

Birthdate _________________ SS# ____________________________ Relation to Patient ___________________________

Employer ____ Occupation ________________________

Employers Address ____ Phone _________________________ ___

Insurance Company ________________________________Subscriber ID # ____________________ Group # _____________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I accept responsibility for payment of all dental services. I will not hold my dentist or any member responsible for any errors or omissions that I may have made in the completion of this form.

____

Print Name Signature Date

DENTAL HISTORY

Answering the following questions accurately will allow your dentist to treat you on a more individual basis.

Patient's Name: ____ Today's date: _____________

1. Are you having any discomfort at this time? YES NO Explain: ______________________________
2. Have you ever had any serious trouble associated with previous dentistry? YES NO
3. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
4. Previous dentist _______________________________________ Last Visit__________________________
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? YES NO
6. Are you satisfied with your smile? YES NO ____
7. How often do you brush? ______________________________ Brush is ☐ Soft ☐ Medium ☐Hard

   Do you use ☐ Mouthwash ☐ Fluoride ☐ Floss ☐ Toothpick ☐ Other ______________

Do you have or have had any of the following?

- ☐ Bleeding, sore gums
- ☐ Unpleasant taste/bad breath
- ☐ Burning tongue/lips
- ☐ Frequent blister, lips/mouth
- ☐ Swelling/lumps in mouth
- ☐ Ortho treatments (braces)
- ☐ Biting cheeks/lips
- ☐ Clicking/popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ Loose teeth
- ☐ Sensitive to hot
- ☐ Sensitive to cold
- ☐ Sensitive to sweets
- ☐ Sensitive to biting
- ☐ Food Impaction
- ☐ Shifting in bite
- ☐ Change in bite
- ☐ Clenching/grinding

  If so, when ______________

MEDICAL HEALTH HISTORY

Are you currently in a physician's care? If so, what for?

____

Physician's Name/Phone Number: ___________________________________Date of Last Visit _________________

Have you had any serious illnesses, operations or hospitalizations? If so, describe and give approximate dates:

____

____

1. Have you ever had intravenous sedation or general anesthesia? YES NO

   Were there any adverse effects? YES NO
2. Do you generally tolerate dental treatment well? YES NO
3. Do you use alcohol? YES NO If so, how much per day? ____________________________
4. Do you smoke? YES NO If so, for how long? _________________________________
5. Do you use spit tobacco? YES NO If so, for how long? _________________________________
6. Are you, or have been, in a drug or alcohol recovery program? YES NO
7. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? YES NO
8. Do you wish to talk to the doctor privately about anything? YES NO

Check (X) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cholesterol
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Mitral Valve prolapse
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Nervous Problems
- ☐ Neurological Disorder
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Skin Rash
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Check (X) if you are taking or using any of the following:

- ☐ Antacids
- ☐ Antibiotics
- ☐ Anticoagulants (blood thinners)
- ☐ Antihistamines, decongestants
- ☐ Anti-inflammatory drugs
- ☐ Natural Remedies
- ☐ Pain Relievers/Narcotics
- ☐ Recreational drugs
- ☐ Steroids
- ☐ Supplements
- ☐ Tranquilizers, antidepressants
- ☐ Vitamins

Please list all current medication: ____

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ALLERGIES

Are you allergic to or had a bad reaction from:

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other:

  ____

  ____

WOMEN ONLY

- ☐ Birth Control Pills
- ☐ Breast Feeding
- ☐ Pregnant/Trying to become pregnant
- ☐ Hormonal Replacement
- ☐ Osteoporosis Medication

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment.

____ ______________

Signature Date Doctor's Initials

CONSENT FOR SERVICES, FINANCIAL POLICIES AND OFFICE POLICIES

FINANCIAL ARRANGEMENTS AND INSURANCE

We accept cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit! Please note there will be a $35.00 returned check fee. Care Credit is a private payment program we offer. For additional information please ask one of our representatives at the front desk. Our fees, when quoted for treatment, will be honored for 90 days. Beyond that, fees may be adjusted to reflect any cost increases.

Most insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ESTIMATED co-payment on the day services are rendered. Many variables exist from carrier to carrier (ex: deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges.

You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Should the account become past due and be referred to a collection agency, the undersigned agrees to pay any and all additional costs/fees and/or interest charged by, or as a result of the referral, to a collection agency, In addition, should the account be referred to an attorney for collections, the undersigned agrees to pay any and all attorney's costs/fees and/or interested charged as a result of the referral.

OFFICE POLICIES

Patients are seen by reservation, emergencies and walk-ins will be seen as time permits. We respectfully ask that you give us 48 hour notice to reschedule your reservation. If you fail to do so, you will be subject to a $75.00 failed/less than 48 hour notice cancellation reservation fee. ______________ Initials

I grant permission to you or your assignee, to contact me to discuss matters related to this form. I understand that photo documentation is necessary throughout treatment and give permission and consent to the use of extra oral and intraoral photography during my treatment. I give my consent and permission for Picacho Family Dental to use any photos taken of me for, education training and/or marketing. I have read the above conditions of treatment and payment and agree to their content.

Print Name: Signature: Date:

Witness: Date:

SIGNATURE ON FILE (INSURED ONLY)

Patient's Name: ____
Last First Initial

I hereby authorize payment directly to Jason T. Lemmon, DDS of the dental benefits otherwise payable to me.

____
Signature (Insured Person) Date

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

Jason T. Lemmon, DDS is authorized to provide any insurance company(s), claim administrator(s), and counseling health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter. I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

____
Patient or Authorized Persons Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement

I, __________________________, have received a copy of this office's Notice of Privacy Practice.
Name

____
Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify) ____