LAKE AUSTIN
FAMILY
DENTAL

PATIENT FORMS

If you have any problems submitting the forms electronically,
please fill out, print and bring them into the office at the time of your next visit.

YOU MUST HAVE ADOBE ACROBAT READER 7.0 OR HIGHER TO FILL OUT THE FORMS.

CLICK HERE TO DOWNLOAD

LAKE AUSTIN FAMILY DENTAL, PLLC

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Parent or Guardian's Name: _____ Gender: _____ Family Status: _____

Social Security: Filled out at Dr.'s Office Birth Date: _____

Home Phone: _____ Work: _____ Cell: _____ Best time to call: _____

Would you like to have upcoming appointment reminders by email? ☐ No ■ Yes

email: _____

Address: _____
Street *Apartment #*

City _____ State _____ Zip Code _____

HEALTH HISTORY

- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Artificial Heart Valve
- ☐ Artificial Joint _____
- ☐ Heart Trouble
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Head Injuries
- ☐ Stroke _____
- ☐ Seizures/Epilepsy
- ☐ Glaucoma
- ☐ Diabetes type ***I or II***
- ☐ Kidney Disease
- ☐ Organ Transplant
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Hepatitis A, B, C
- ☐ Anemia
- ☐ Hemophilia
- ☐ Excessive Bleeding
- ☐ Rheumatism/Arthritis
- ☐ Sinus Problems
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ Fainting
- ☐ Benign Growths
- ☐ Cancer _____
  - ☐ Radiation Treatment
  - ☐ Chemotherapy
- ☐ HIV/AIDS
- ☐ Immune Deficiencies
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Stomach Problems
  - ☐ Ulcers
  - ☐ GERD
- ☐ Low Thyroid
  - ☐ Thyroid removal
  - ☐ Replacement therapy
- ☐ Hyperthyroid
  - ☐ Nervous Disorders
- ☐ Mental Disorders
- ☐ Depression/Anxiety
- ☐ ***Pregnancy*** - currently
  Due date: _____
- ☐ Bisphosphonate meds

DRUG ALLERGIES

- ☐ Ibuprofen Allergy
- ☐ Aspirin Allergy
- ☐ Tylenol Allergy
- ☐ Codeine Allergy
- ☐ Hydrocodone Allergy
- ☐ Tetracycline Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa drug Allergy
- ☐ Erythromycin Allergy
- ☐ Cephalosporin Allergy
- ☐ Anesthetic Allergy

OTHER ALLERGIES

- ☐ Latex Allergy
- ☐ Acrylic Allergy
- ☐ Metal Allergy
- ☐ Adhesive Allergy
- ☐ Adverse Reaction to any other drugs/other:

_____

OTHER Health Problems not listed:

_____

• What is your weight _____lb? Height? _____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician?
☐ Yes ☐ No
If yes, please explain: _____

• Physician name and number _____

• Please list all Medications and vitamins and supplements you are currently taking: (or provide list to photocopy)

_____

_____

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ *Date:* _____
Signature of patient, parent or guardian

_____ *Date:* _____
Signature of doctor reviewing medical history

DENTAL HISTORY

Primary Reason for appointment: ☐ Exam ☐ Emergency ☐ Esthetic Consultation & Smile Makeover

Do you have a specific dental problem you would like addressed? _____

Do you have dental examinations on a regular basis? ☐Yes ☐No

Name of your previous Dentist? _____ When was your last visit? _____

Are your teeth Sensitive to: ☐ Cold ☐ Hot ☐ Sweet ☐ Biting ☐ Touch

Do you think you have active decay? ☐Yes ☐No

Do you think you have gum disease? ☐Yes ☐No

Do your gums bleed? ☐Yes ☐No

Have you been taught to control gum disease? ☐Yes ☐No

How often do you brush? ☐ Twice Daily or more ☐ Once Daily ☐ Weekly ☐ Not on a regular basis ☐ Do NOT brush

How often do you floss? ☐ Twice Daily or more ☐ Once Daily ☐ Weekly ☐ Not on a regular basis ☐ Do NOT floss

Have you ever had ☐ Scaling and Root Planing? ☐ Gum Surgery? ☐ TMJ therapy/surgery? ☐ Braces?

Do you clench or grind your teeth? ☐Yes ☐No

Do you wear a grinding guard/night guard? ☐Yes ☐No

Do you have clicking or popping in the jaw joint? ☐Yes ☐No

Do you have discomfort in the jaw joint? ☐Yes ☐No

Do you have any sores, ulcers or growths in your mouth? _____

Do you smoke or chew tobacco products? ☐Yes ☐No If yes, how much/for how long _____

Do you drink alcoholic beverages? ☐Yes ☐No If yes, how often? ☐ Never ☐ Seldom ☐ More than 2/day

Do you use recreational drugs? ☐Yes ☐No

Have you're past dental experiences always been positive? ☐Yes ☐No Please explain: _____

Do you have any fear of dental treatment? ☐Yes ☐No

Are you pleased with the appearance of your teeth? ☐ Yes ☐ No

Would you like your teeth whitened? ☐Yes ☐No

Describe any other changes you would like in the appearance of your teeth: _____

Please sign that the above information is true to the best of your knowledge

_____ Today's Date: _____

Signature of patient, parent or guardian

_____ Date of Birth: _____

Print Patient Name *Last* *First* *Mi*

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

Another patient _____

Friend or Relative _____

☐ Insurance ☐ Web Page ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: _____ Date: _____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security: Filled out at Dr.'s Office Birth Date: _____

Home Phone: _____ Work: _____ Cell: _____ Best time to call: _____

Address: _____
Street *Apartment #*

City: _____ State: _____ Zip Code: _____

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street *Apartment #*

City: _____ State: _____ Zip Code: _____ Phone: _____

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street *Apartment #*

City: _____ State: _____ Zip Code: _____

Insured's Employer Name:

Employers Address: _____
Street *Apartment #*

City: _____ State: _____ Zip Code: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street *Apartment #*

City: _____ State: _____ Zip Code: _____

Insured's Employer Name:

Employers Address: _____
Street *Apartment #*

City: _____ State: _____ Zip Code: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Patient Name: _____ Date Of Birth: _____ / _____ / _____
Last *First* *MI*

PLEASE READ AND INITIAL EACH STATEMENT:

_____ Consent for treatment: I do hereby consent to necessary examinations procedures and/or treatments prescribed by my dentist, his/her assistants, or designee as is necessary in his/her judgment.

_____ Financial responsibility: I understand that I am financially responsible for all charges whether or not they are covered by insurance. Payment is due at the time of service. As a condition of your treatment by this office, financial arrangements must be made in advance, prior to treatment. The practice depends upon reimbursement from the patients and the insurance companies for the cost incurred in patient care. However, the patient is responsible for any unpaid balances remaining after insurance payment. (All insurance companies give you one year to collect from them, then it become the patient's responsibility, make sure you follow up on your dental insurance.) Cash, credit card, check, or debit may be used to make payments. We cannot legally accept a post-dated check. 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. All unpaid balances exceeding 90 days (without prior arrangements) will be turned over to a collections agency.

_____ Patient's Co-payments / Insurance: I understand that any co-payment that is collected at the time of visit is an estimate. I understand my insurance might determine that they will pay for a less costly service than the covered service performed by the dentist. **For example, Composite fillings and porcelain crowns may be downgraded to the amalgam filling or full gold crown benefit if your insurance plan pays a benefit based upon a less costly service, we will charge the patient or patient's dependent for the difference between the service that was performed and the less costly service. This may be the case, even if the service if performed by an in-network dentist. I also 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's examination. Furthermore, I understand that it is ultimately my responsibility to find out if my insurance is in or out of network with Lake Austin Family Dental, PLLC.
***Each patient is ultimately responsible for verifying his or her individual insurance plan coverage.

_____ Assignment of benefits: I request that payment of authorized insurance benefits be made on my behalf to Lake Austin Family Dental, PLLC for any service furnished. I understand that Lake Austin Family Dental, PLLC submits my dental insurance claims to my insurance company as a courtesy. I hereby give by Lake Austin Family Dental, PLLC permission to submit all of my dental insurance claims to my dental and or medical insurance company on my behalf electronically and by mail, and to receive payment from my insurance company directly. A photocopy of this assignment is to be considered as valid as the original until revoked.

_____ Appointment Deposit: Procedures scheduled for 1 hour or more will require a prepayment deposit. This amount will be determined based on the specific treatment scheduled. This amount will be applied toward the full amount due at the time services are rendered.

_____ Returned check policy: I understand that I will incur a fee of $ 35.00 for any returned checks.

_____ Contact information: I understand I am responsible for providing accurate billing and contact information. I also understand that it is my responsibility to inform Lake Austin Family Dental, PLLC of any changes to keep this information current.

_____ Cancellation & No – Show Policy: It is Lake Austin Family Dental, PLLC policy to optimize the time our doctors and hygienists spend with each patient. This is intended to give every patient a personalized dental visit. Therefore, each patient's appointment is scheduled for the appropriate time needed. As a courtesy, Lake Austin Family Dental, PLLC will attempt to contact each patient/guardian to confirm your appointments the day before; ultimately it is the your responsibility to keep track of your appointments. Patients/guardians who arrive 10 min late from the time the appointment is scheduled, or cancel an appointment less than 24 hours from the scheduled time will incur a NO SHOW / CANCELLATION FEE of $75.00 (Appointment with Doctor) and $50.00 (Appointment with Hygiene). Once you have missed an appointment we reserve the right to collect a non-refundable deposit to secure another appointment. This applies per patient/per appointment. Lake Austin Family Dental, PLLC reserves the right to discontinue patient care if an established patient misses three (3) appointments without providing one business day notice of cancellation. Patients or guarantors/guardians of established patients will be notified in writing if there have been three missed appointments. This will result in the termination of the dentist/patient relationship.

_____ Email correspondence: I agree to allow Lake Austin Family Dental, PLLC to correspond with me/my family by email. This includes appointment reminders and other correspondence. Listing or not listing my email on my patient paperwork shows that I allow or don't allow this type of correspondence.

_____ Authorization to release information: I, the undersigned, do hereby authorize, Lake Austin Family Dental, PLLC to release information regarding my care to any referring providers/specialties. This includes necessary transfer of information/x-rays by email/electronic transfer. Lake Austin Family Dental, PLLC complies with all HIPPA regulations.

_____ Photographic Release I authorize Lake Austin Family Dental, PLLC and its employees to take dental of my teeth and face as it pertains to my treatment. These photographs will be retained as a part of my dental record and may be used for my dental treatment such as sending to a lab for reference when making veneers, or descriptive purposes. If Lake Austin Family Dental, PLLC requests to use a full-face picture for advertising or otherwise I will be contacted and asked to sign as additional consent form. I may choose to allow all photographs except those of my full face to be used. I do not expect financial or other compensation if my photographs are used by Lake Austin Family Dental, PLLC.

In consideration for the professional services rendered to me by the doctor and /or staff, I agree to pay the reasonable value of said services at the time said services are rendered/ I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver or any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

_____ Date _____

Signature of Patient/Responsible Party

HIPAA RELATED FORMS

Patient Name: _____ Date Of Birth: ____ / ____ / ____
Last *First* *MI*

***Acknowledgment Of Receipt Of Notice Of Privacy Practices

Please read the hard copy provided to you or request a personal photocopy

I have reviewed the Lake Austin Family Dental, PLLC Notice Of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document per my request.

Signature Of Patient Or Parent/Guardian: _____ Date: _____

***HIPAA Authorization for Disclosure Of Confidential Information

This authorizes Lake Austin Family Dental, PLLC to provide and discuss any information regarding my treatment or account information to the following:

(For example: spouse, relative, caregiver, grandparent, etc...)

First Name	Last Name	Relationship to patient	Date of Birth
First Name	Last Name	Relationship to patient	Date of Birth
First Name	Last Name	Relationship to patient	Date of Birth

☐ I do not wish to share my dental information with anyone at this time.

☐ **I agree that a photocopy of this authorization may be considered valid.**

_____ Date _____
Signature of Patient/Responsible Party

SUBMIT FORM