PATIENT MEDICAL HISTORY *(Please fill out both sides completely)*

PATIENT'S NAME _____ DATE OF BIRTH _____

MEDICAL PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

IN CASE OF AN EMERGENCY, NOTIFY _____ PHONE _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND THE MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. Are you in good health	☐	☐
2. Have there been any changes in your general health within the past year	☐	☐
3. Date of your last physical exam _____		
4. Physician's Name _____		
Address _____		
Phone No. _____		
5. Are you now under the care of a physician	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness	☐	☐
Please Explain _____		
7. Are you taking any medicine(s), including non-prescription medicine	☐	☐
If YES, what medicine(s) are you taking _____		
8. Have you had any abnormal bleeding	☐	☐
9. Do you bruise easily	☐	☐
10. Have you ever required a blood transfusion	☐	☐
11. Have you had a recent weight loss	☐	☐
12. Have you ever taken Fen-Phen or Redux	☐	☐
13. Do you use tobacco	☐	☐
14. Do you or have you used controlled substances	☐	☐
15. Are you wearing contact lenses	☐	☐
16. Do you have any disease, condition or problem not listed here that you think I should know about	☐	☐

WOMEN ONLY:

Are you pregnant or think you may be pregnant	☐	☐
Are you nursing	☐	☐
Are you taking birth control pills	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
Local anesthetics like novocaine	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Any metals (e.g. Nickel, Mercury, etc.)	☐	☐
Latex / rubber	☐	☐
Other (please specify) _____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
Rheumatic heart disease or rheumatic fever	☐	☐
Scarlet fever	☐	☐
Heart defect or heart murmur	☐	☐
Heart trouble, heart attack or angina	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
High/low blood pressure	☐	☐
Congenital heart problem	☐	☐
Swelling of feet, ankles, hands	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐
Stroke	☐	☐
Sinus trouble	☐	☐
Lung or breathing problems	☐	☐
Asthma or hay fever	☐	☐
Fainting or dizzy spells	☐	☐
Diabetes	☐	☐
AIDS or HIV virus	☐	☐
Thyroid problems	☐	☐
Allergies	☐	☐
Joint replacement or implant	☐	☐
Kidney trouble	☐	☐
Tuberculosis	☐	☐
Persistent cough	☐	☐
Chemotherapy (Cancer, Leukemia)	☐	☐
Sexually transmitted disease	☐	☐
Epilepsy or seizures	☐	☐
Anemia	☐	☐
Nervousness	☐	☐
Tumors	☐	☐
Mental health care	☐	☐
Back problems	☐	☐
Chemical dependency	☐	☐
Mitral valve prolapse	☐	☐
Cortisone treatment	☐	☐
Cold sores / fever blisters	☐	☐
Hypoglycemia	☐	☐

FOR OFFICE USE ONLY

MEDICAL UPDATE
(Each Visit)

Visit	Today's Date	Initial	Changes Yes/No
1			
2			
3			
4			
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7			
8			
9			
10			
11			
12			
13			
14			
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PATIENT DENTAL HISTORY *(Please fill out both sides completely)*

PATIENT'S NAME_____ DATE OF BIRTH_____

Are you having any dental discomfort or problem at this time?_____
Explain_____

Have you ever had any unpleasant experience in a dental office?_____
Explain_____

Did you ever wear braces or retainers?_____ When?_____

Name of Orthodontist:_____

Are any of your teeth sensitive to: Hot?_____ Cold?_____ Pressure?_____ Sweets?_____

Are you dissatisfied with the appearance of your teeth?_____ Explain_____

_____

What was the approximate date of last cleaning?_____ X-rays?_____

How often do you floss your teeth?_____ Type of toothbrush used?_____

Do you use a water-jet or other such device?_____

Does food wedge between your teeth?_____ Where?_____

Have you ever had gum treatment or gum surgery?_____ Explain_____

_____

Do you ever feel that you have bad breath?_____

Do you have a bad taste in your mouth?_____

Do you ever notice pain or ringing in your ears?_____

Do you have any sinus problems?_____

Are you aware of any lumps or swelling in your mouth or neck?_____

Do you smoke?_____

Is there anything else you think the Dentist should know or is there anything that you would like to discuss with the Dentist?_____

_____

_____

_____

_____

_____ _____ _____ _____

Patient Signature Date Dentist Signature Date

Lake Mary Dental
114 Timberlachen Circle
Lake Mary Fl. 32746

Patient and Insurance Information

Patient

Name_____ Cell#_____
Home#_____ Address_____
City _____ State_____ Zip code_____
Work#_____
Birthday_____/_____/_____
Email_____
Social Security_____-____-_____

On a scale from 1 to 10 (1 worst 10 best)
I rate my smile_____

Who may we thank for referring you to our office?

_____

I have no insurance____

Policy Holder: (If different from above)

Name_____ Cell#_____
Home#_____ Work#_____
Birthday_____/_____/_____
Email_____
Social Security_____-____-_____

Name of Insurance Company_____
Insurance Phone #_____
Member ID#_____
Group#_____

Broken Appointment Fee

It is our opinion that your time is valuable and it has been our scheduling philosophy that "You deserve our undivided attention." It is for these reasons that we do not double book and we accept drop ins only in the event of an emergency.

When we schedule your dental visit, that time is yours; it belongs to you! Flat tires, sick children, and family emergencies will and do happen and naturally we understand that because it happens to all of us. However, when missed or broken appointments occur, it affects everyone. It results in increased overhead, wasted time and manpower, and eventually higher patient fees. When you miss or cancel your appointment without prior notification, **Lake Mary Dental** will charge a broken appointment fee of **$40.00 per scheduled hour.** To avoid this fee please notify us at least up to **48 hours** (2 business days) in advance of your appointment and speak with a staff member; leaving a voicemail message is not a guarantee we will receive it in time to avoid the cancellation fee.

One the other hand, procedures may sometimes take longer than planned due to unforeseen circumstances, but our primary objective is to be on time and on schedule. You can help us by being punctual, arriving a few minutes before your scheduled appointment time.

If you have any questions about insurance, treatment, or fees please address them with one of our staff members before your scheduled appointment.

_____ _____

(Print Name) Patient or Legal Guardian Date

_____ _____

(Signature) Patient or Legal Guardian Date

Financial Policy of Lake Mary Dental

As a courtesy to our patients, Lake Mary Dental will submit all dental claims to your primary insurance company. If claims are not paid by the insurance company for any reason, it becomes the responsibility of the patient or guardian (if the patient is a minor). Prior to submission of claims the patient/guardian will be thoroughly informed of all procedures, options, and estimated cost before starting treatment. Please be advised that treatment is determined by what is deemed necessary by your dentist, not by what your insurance covers. Should you have any questions or concerns, please feel free to address them with us.

We will estimate a **"patient portion"** based on the insurance information you have provided. It is our policy that the **"patient portion"** is to be paid in full at the time the procedure is scheduled. We will then file the claim with your insurance company. If insurance pays more then the estimated cost, we will credit your account or issue a refund for the difference. If the insurance company pays less than the estimate, you agree to pay the difference within 15 days of notification. If for any reason insurance payment is delayed for more than 60 days after submission, you agree to pay the entire balance within 15 days of notification.

Full payment is required to reserve appointments. The payment will be applied towards treatment.

All fees charged are the sole responsibility of the undersigned. Any balance outstanding beyond 30 days is subject to a 1.5% service charge (18% APR) with a minimum monthly service charge of $1.50. A late charge fee will b assessed on any payment received 10 or more days after the due date. Returned checks will be charged $25 or 10% of the check amount- whichever is greater.

_____ (Initials)

The undersigned agrees to pay all reasonable attorney fees, court costs, and collection fees should collection activity become necessary. If this account is assigned to a collection agency, an additional fee of 40% of the outstanding balance will be added to the account.

I have read and understand Lake Mary Dental's Financial Policy.

_____ _____

Print Name Date

_____ _____

Signature Date

LAKE MARY DENTAL

Tel: 407.330.3801 • Fax: 407.330.5739 • 114 TIMBERLACHEN CIRCLE • LAKE MARY,FL 32746 • WWW.LAKEMARYDENTAL.COM
D. Ravi Lall, D.D.S. Kathleen Du Lac, D.D.S

Dental/Medical Records

We respect the confidentiality of your dental/medical records. We only release information upon your written request or in response to a court subpoena. We will provide you with copies of your records upon your written request. In the case of a minor child, only a legal guardian may request copies. A spouse or relative may NOT request your records.

I authorize you to release my dental/medical information records to my dental plan. I authorize you to release my dental/medical information and records to other dentists and physicians for consultation purposes

_____ _____
(Patient or Legal Guardian Signature) Date

Dental x-rays are part of your dental/medical records. All original x-rays and records are kept in our files. Copies of the x-ray will be provided to you upon written request. If x-rays are needed for referral to a specialist or by our dental plan, they will be provided at NO charge. If records are requested for any other personal purpose a $20.00 charge will be applied.

_____ _____
(Patient or Legal Guardian Signature) Date

Deoraj Lall, DDS
Lake Mary Dental
114 Timberlachen Circle
Lake Mary FL, 32746
407-330-3801

Protected Health Information Release Authorization

Full Name: _____ Date of Birth: _____

This will authorize this facility, **Lake Mary Dental**, to use or disclose my protected health information to the following person(s) listed below for the following purpose:

Complete copy of medical records. _____ (Initial)

Other (describe) _____ (Initial) _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Dates of care include: _____ to _____

The information authorized for disclosure, if applicable may relate to Psychotherapy notes only, mental illness (excluding psychotherapy notes), HIV related illness, AIDS & Drugs or alcohol treatment (further disclosure prohibited or governed by 42 CFR Part 2) unless you strike through which records you do not want released with a line through it.

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that this authorization may be revoked in writing and delivered to the privacy office of at any time, although 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 information used or disclosed pursuant to this authorization could be subject to disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that the facility listed above shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure.

I understand that this facility shall have the opportunity to obtain direct or indirect remuneration in the nature as a result of this authorization.

Name: _____

Signature: _____ Date: _____

Air Abrasion and Insurance

We are proud to offer our patients the enormous benefits of Air Abrasion. Air Abrasion is the latest development in conservative, comfortable and painless dentistry. With the help of Laser detection, we are now able to diagnose and treat tooth decay in it's early stages and usually with NO anesthetic and NO drilling!

Due to the fixed cost of the Air Abrasion equipment, the fee we charge for the restoration can not be discounted. Therefore, we offer this state of the art technique as an option that is not subject to dental plan discounts. If you desire a restoration that does qualify for dental insurance discounts, we offer several types of conventual fillings. We will be happy to file a claim with your dental insurance for the Air Abrasion; however, most dental plans will only pay according to the least expensive options. To be able to get the best benefits from your insurance we use the **ADA** code for **standard** composite resin (tooth colored) fillings.

The patient portion on your treatment proposal is only and **estimate.** If you want more specific information on your coverage, we suggest that you request a "Pre- determination of Benefits" from your dental insurance plan. Your insurance will usually base it's benefits on the most economical treatment. Please consider the points before selecting to upgrade to the option of Air Abrasion.

REMEMBER: AIR ABRASION IS AN OPTIONAL UPGRADE AND DOES NOT QUALIFY FOR DENTAL PLAN DISCOUNTS. THEREFORE, YOU WILL NEED TO PAY ANY AMOUNT THE INSURANCE DOES NOT COVER.

Signature: _____ **Date:** _____

Cerec and Insurance

We are proud to offer our patients the enormous benefits of Cerec Porcelain restorations. They represent the epitome of modern dental technology. The conserve tooth structure and save time.

Due to fixed cost of the Cerec machine, the time and material involved; the fee we charge for these restorations **can not** be discounted. Therefore, we offer these upgraded restorations as options that are not subject to discounts of dental plans. If you desire a restoration that does qualify for dental plan discounts, we have those available. We will be happy to file a claim with your dental insurance for the Cerec restoration; however, most dental plans will only pay according to the least expensive option. To be able to get the best benefit from your insurance, we use the **ADA** code for a **standard** porcelain restoration.

The patient portion on your treatment proposal is only an **estimate**. If you want more specific information on coverage, we suggest that you request a **"Pre-Determination of Benefits"**. Your insurance will usually base it's benefits on the most economical treatment. Please consider these points before selecting to upgrade to the option of a Cerec restoration.

REMEMBER: CEREC RESTOATIONS DO NOT QUALIFY FOR DENTAL PLAN DISCOUNTS.

Signature: _____ Date: _____