PATIENT INFORMATION UPDATE

Updated 8/10/21

Welcome to Lifetime Smiles! To assist us in serving you, please complete the following confidential form.

Patient's name _____ Preferred name_____ DOB_____SSN _____
If minor, parents' names _____
Home phone _____ **Cell phone** _____
Email Address _____
(Cell phone and email used to help you with appointment confirmations)
Mailing address _____ City _____State ____ Zip _____
Family Status ❑ Single ❑ Married ❑ Child ❑ Other Gender ❑ Male ❑ Female

INSURANCE INFORMATION: ❑ Not covered by insurance ❑ New Insurance ❑ No Changes

Name of Insured_____Insured's Social Security number _____Insured DOB_____
Insurance Co._____ Group number_____ ID number _____
Employer_____
Business address_____ City_____ State_____ Zipcode_____

MEDICAL HEALTH INFORMATION

Please check if you have or have had any of the following:

- ❑ Abnormal bleeding
- ❑ **Artificial joint or Valve** *Date placed*_____
- ❑ Cancer or Tumor
- ❑ Chemotherapy or Radiation *Date*_____
- ❑ **Diabetes**
- ❑ **Heart disease, Angina, Heart attack**
- ❑ **High Blood pressure**
- ❑ High Cholesterol
- ❑ Osteoporosis
- ❑ Pacemaker *Date placed*_____
- ❑ Stroke
- ❑ **Hepatitis**
- ❑ Other:_____

Are you taking any of the following?

- ❑ **Blood Thinners**
- ❑ Antibiotics
- ❑ High blood pressure medicine
- ❑ Insulin or Diabetes drug
- ❑ Osteoporosis medicine

Have you ever taken Bisphosphonates, a class of drugs used to treat osteoporosis or bone cancer?
❑ yes ❑ no

Allergies or Adverse Reactions:

- ❑ Penicillin
- ❑ Codeine, hydrocodone, or other narcotics
- ❑ Sulfa drugs
- ❑ Other:_____

Please list all medications you are currently taking:_____
_____
_____
_____

Do you snore? ❑ yes ❑ no

Have you ever had a sleep study?
❑ yes ❑ no

Do you smoke or use chewing tobacco?
❑ yes ❑ no

Women:

- ❑ Pregnant or may be pregnant *Expected delivery date*: _____
- ❑ Currently Breastfeeding

Name of your physician:_____ Phone_____

Have you seen a physician since your last visit at our office? _____

Please list the name and phone number of your emergency contact:_____

Signature of patient (or parent) _____ Date _____

Office Policies

Thank you for choosing our office for your dental needs! We are so glad you are here! We appreciate your trust and look forward to working with you. In order to better serve you, we ask that all patients read and sign our ***OFFICE POLICIES***. If you have any questions, please ask the front desk.

1. **INSURANCE:** We are pleased that you have dental insurance! Your dental insurance benefits are a contract between yourself, your employer, and your insurance carrier. We are not part of that contract. As a courtesy to you, we will try to verify your insurance eligibility benefits prior to your appointment. Please notify us immediately if your insurance coverage changes. Not all dental services are covered under your dental policy. Each policy varies in exceptions, exclusions, waiting periods, and limitations. Your insurance is your responsibility; you are ultimately responsible for knowing all guidelines, exclusions, waiting periods, and limitations. Should you have any questions or need explanations about your insurance benefits, please ask. **Insurance estimates are provided as a courtesy, and are never a guarantee of your benefits.** In the event that your insurance carrier pays less than the estimated amount, you are responsible for the remaining unpaid balance. **You are responsible for the balance in the event that insurance benefits are denied**.

2. **FILING INSURANCE:** As a courtesy to you, we will electronically file insurance claims and accept assignment of benefits on your behalf. Often, the insurance company will request additional information such as a college student's full-time status, proof of enrollment, etc. Failure to provide additional information to our office may result in a denial of insurance benefits.

3. **PAYMENT:** Payment is due at the time of services rendered (this includes yearly deductibles, copayments, and/or estimated out of pocket portions). Additionally, if you have an outstanding balance following an insurance payment, you will be expected to pay the balance prior to additional treatment. Our office offers Third Party Financing if needed to assist you in paying for necessary treatment.

4. **OVER DUE BALANCES:** If your account balance exceeds 60 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days of notification, your account will be turned over to a collections agency. In this event, there is a collection fee that will be added to the balance. The collection agency will report any unpaid balance to the major credit bureus.

5. **RETURNED CHECKS:** There will be a $35 fee for all returned checks. In the event of a returned check, your balance and fee must be paid via credit card or money order within 10 days of notification. If it is not paid, we will treat it as an over due balance.

6. **CHANGES IN PERSONAL INFORMATION:** Please notify our office of any changes in your address, telephone numbers, or email address.

7. **CANCELLATIONS/FAILED APPOINTMENTS:** We reserve the right to charge a fee of $75-$150 for any appointment missed or cancelled without a 24 hour notice. If a conflict with your appointment time arises, please call us immediately.

8. **INTERNET COMMUNICATIONS:** We are a paperless office! By signing the office policies form below, I also grant my permission to the dental office to upload and store confidential information to the secured website of the dental practice. I also grant my permission to the dental practice to file my insurance claims electronically.

***I have read and understand the office policies of the practice and agree to the terms.**

Patient Name:_____Signature:_____ Date:_____
(or guardian if applicable)

Notice of Privacy Practices Patient Acknowledgement

As of December 1, 2015, Lifetime Smiles, Suny Pahouja, DDS, Inc. has updated the Notice of Privacy Practices. I have read and understand the practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. I can ask for a copy of the privacy practices at any time.

Patient Name:_____Signature:_____ Date:_____
(or guardian if applicable)