Lifetime Smiles Dental Care

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& Associates

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Welcome, so we may provide you with the best possible care and get to know you better; please complete this Medical & Dental History Form. Please keep in mind that all information is kept Confidential.

Date: ____________________

Preferred Name: ____________________

Name: ____
First | Middle Initial | Last

Residence/ Group Home Address:

____
City | State | Zip

Home Phone: ____________________ Additional Contact #: ____________________

D.O.B.: _____ / _____ / _____ Social Security #: _____ / _____ / _____

Sex: Male or Female Medicaid #: ____________________

Please provide us with as much information possible, to the best of your knowledge.....

Who primarily brings the patient to appointments? ____________________ ____________________
Name | Phone

Is the patient legally competent to sign consents, if not who is? ____________________ ____________________
Name | Phone

Support Coordinator: ____________________ Phone/Cell: ____________________

Support Coordinator Address:

____
City | State | zip

For office use only

Recipient Id: ____________________

Patient Name: ____________________

Medical History

Primary Care Physician: ____________________ Telephone: ____________________

Pharmacy: ____________________ Telephone: ____________________

Primary Diagnosis: ____________________

Please indicate the appropriate response by circling Yes or No:
If yes please elaborate . . .

Yes No Have you been under the care of a medical doctor in the past TWO years?

____

Yes No Have you been hospitalized? Any sedation history?

____

Yes No Have you ever had a reaction to a local anesthetic or sedation?

____

Yes No Have you ever been told to Pre-Medicate with Antibiotics prior to Dental Appointments?

____

Yes No Are you Allergic to anything?

____

Yes No Are you Allergic to Latex?

Yes No Are you Pregnant?

Please List all Current Medications:

____

____

____

____

____

Doctor's Initials: ________

Patient Name: ______________________________

Medical History Continued . . .

Please indicate the appropriate response by circling, Yes or No:

Do you have, or have you had, any of the following . . .

Condition		
AIDS/HIV	Yes	No
Alzheimer's	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina	Yes	No
Arthritis/Rheumatism	Yes	No
Artificial Joints	Yes	No
Asthma	Yes	No
Blood Disease	Yes	No
Breathing Problem	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Chest Pains	Yes	No
Cold Sores	Yes	No
Cortisone Medicine	Yes	No
Diabetes	Yes	No
Drug Addiction	Yes	No
Emphysema	Yes	No
Epilepsy/Seizure	Yes	No
Excessive Bleeding	Yes	No
Fainting/Dizziness	Yes	No
Frequent Headaches	Yes	No
Glaucoma	Yes	No
Gastric Bypass	Yes	No
Heart Murmur	Yes	No
Heart Pace Maker	Yes	No
Heart Trouble	Yes	No
Heart Valve (Artificial)	Yes	No
Hemophilia	Yes	No
Hepatitis A ( ) B ( ) C ( )	Yes	No
Herpes	Yes	No
High or Low Blood Pressure	Yes	No (choose one)
Hives/Rash	Yes	No
Hypoglycemia	Yes	No
Kidney Trouble	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Lung Disease	Yes	No
Psychiatric Care	Yes	No
Radiation Treatment	Yes	No
Renal Dialysis	Yes	No
Rheumatic Fever	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Spina Bifida	Yes	No
Stomach/Intestinal Disease	Yes	No
Stroke	Yes	No
Thyroid Disease	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Tumors or Growths	Yes	No
Use Tobacco Products	Yes	No

Comments or any additional information:

____

____

____

____

____

Doctor's Initials: ________

Patient Name: ____________________

Dental History . . .

Are you currently having any Dental Problems at this time? ____________________

When was your last Dental Appointment? ____________________

Date of Last Cleaning: ____________________ Date of Last X-rays: ____________________

Previous Dentist: ____________________

Name Location Phone #

What didn't you like about your previous office? ____________________

How often do you:

Brush ____________ **Floss** ____________ **Whiten** ____________

See your Hygienist for cleanings? ____________________

Have you ever been told/treated for Periodontal Disease? Yes No Date: ____________

What dental products are you using at home? ____________________

Are your teeth Sensitive to:

Heat: Yes No **Cold:** Yes No **Sweets:** Yes No **Biting:** Yes No

Do you notice?

Bleeding upon brushing? Yes No Gum Recession? Yes No

Swelling of the Gum Tissue? Yes No Bad Breath/Taste? Yes No

Frequent Headaches Yes No Loose Teeth Yes No

Discomfort/Popping/Clicking of your Jaw? Yes No

Grinding or Clenching of your teeth? Yes No

Do you have a Night Guard? Yes No

On a Scale of 1-10 how would you rate your:

Smile: ____________________ Dental Health: ____________________

Would you like your teeth: Whiter: Yes No Straighter: Yes No

If you could change one thing about your smile what would it be?

____

What can we do to make your visit more comfortable?

____

Privacy Notice and Consent

Lifetime Smiles Dental Care, Christopher M. Donato and Associates; believes our patients have the right to Privacy and that their personal financial and health information should be kept confidential. Our belief in your right to privacy is nothing new. However, new laws now require that we notify you about our privacy in writing.

How do we use your personal health information?

We will use your personal health information to provide, coordinate, or manage your dental treatment and any related services. This may include providing necessary information to pharmacy personal, laboratory technicians, or to third party health care providers. For example, we might need to disclose information, as necessary, to a home health agency that provides care to you, or to a physician or dental specialist to whom you have been referred to ensure that they have the necessary information to diagnose or treat you.

Personal information may be given to your insurance company if necessary to facilitate payment of your claims.

On occasion your personal information may be used for/in supporting the practices business operations. These activates include, but are not limited too, quality assessments activities, employee review activities, training of dental students, licensing, and conductions or arranging for other business activities. We may use a sign-in sheet at the receptionist desk where you will be asked to sign your name and indicate the practitioner you are to see. We may also call you by name in the reception area when ready to bring you back. We may use or disclose your protected health information, as necessary; to contact you to remind you of your appointment or discuss any questions we may have regarding your account.

We may also use or disclose your personal information in the following situations without your authorization as required by law: Public health issues/communicable diseases, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners request, research, criminal activity, national security, and workers compensation.

What are your rights?

- You have the right to inspect and copy your personal information
- You have the right to request a restriction of your personal information.
  - This means you may ask us not to use or disclose any of your personal information for the purposes of treatment, payment, or operations.
  - You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for that notification purposes as described in this Notice of Privacy Practices.
    - Your request must state the specific restriction requested, in writing, and to whom you want the restriction to apply.
- Your dentist is no required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit the use and disclose of such information, it will not be restricted. You then have the right to use another Health Care Professional.
- You have the right to request/receive confidential communications from us by alternative means or at an alternative location.
- You may have the right to have your dentist amend your personal health information
- You have the right to receive an accounting of certain disclosures we have made, if any, of your personal health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object of withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You can be assured there will be no ill-will following a complaint by you.
This notice was published and becomes effective on/before December 10, 2010.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected personal/health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number (813) 872-7909.

This is to certify that I have read and understand the above information. By signing this statement I am giving Lifetime Smiles Dental Care, Christopher M. Donato and Associates and its team member's permission to release my personal information as described above.

______________________________ ____________________

Signature of Patient / Legal Guardian Date

Office and Financial Policy

Welcome and thank you for choosing Lifetime Smiles for all your Dental needs. We are committed to providing you with the highest quality of dental care, in an efficient, timely, and cost effective manner. We hope that by providing you with our policies in advance you will have a great experience with our office and gain a better understanding of the financial obligation related to your dental treatment.

Treatment Plan

We have prepared for you an itemized Treatment Plan that outlines the sequence of dental services to be provided. The Treatment Plan reflects the clinical findings and standard of care procedures dentally necessary for you to attain the smile and overall dental health you are seeking. Due to the nature of dentistry, treatment and fees may change; if this occurs will inform you prior to rendering any services.

Estimated Fees

The Treatment Plan has an estimation of what we *expect* your insurance carrier to pay. Each insurance benefit plan is slightly different in its covered services; it is the insurance carrier's discretion for final payment. If you have any questions on your insurance coverage, please feel free to contact your insurance company or your Employer's Human Resources Department.

We understand that your insurance carrier may deny, adjust, or pay an alternate benefit; so as a courtesy to you, we will send a bill for the amount due. Your insurance carrier will provide an explanation of benefits. There may be a balance due after your claim is processed by your insurance carrier. As the policy holder and account guarantor, you are responsible for all fees not paid by your insurance carrier.

Insurance Benefits

As the insurance holder, you are responsible for knowing your insurance benefits and coverage. As a courtesy to you, we will accept the insurance assignment of benefit. We will gladly file your insurance claim on your behalf. We will allow 30 days from the date of service for the insurance company to pay. If the insurance carrier does not pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage/benefits (i.e. deductibles, non-covered services, co-insurance, pre-existing conditions, reasonable and customary charges, etc.) You are responsible for the timely payment of your account.

Payment Types

Payment of fees is due at the time services are rendered. For your connivance, we accept Cash, Personal Checks (with Identification), Visa, MasterCard, Discover, Care Credit, Chase Health Advance, and Springstone Financial.

There is a $25 fee for all returned checks.

Payment Plan and Financing Options

As convenience for you, we have made arrangements with Third-Party Healthcare Lenders to provide a financing option that will allow you to pay for your dental care over an extended period of time. This option is based on Approval. Please ask our Financial Specialist how you can apply.

No Shows and Cancellation Policy

24 hours notice is required for all cancellations. Each Patient is allowed ONE no show or cancellation without 24hours notice without penalty. Any additional broken appointments will result in a $35 charge to your account.

Non-Payment Recourse and Disclosure

As a courtesy we do not charge interest on accounts until your account is outstanding past 90days. Any balances unresolved and outstanding past 90days without prior arrangements with our office will be sent to an Attorney or Collection Agency. A collection fee of 33% for balances less than 1 year; and 50% for balances over 1 year will be added to your account.

I have read, understand, and have agreed to the above office and financial policies. I hereby attest that I have given and agree to provide current personal, demographic, and insurance information and authorize release of information necessary to fill insurance and or collection of my account.

______________________________ __________________________

Signature of Patient / Legal Guardian   Date