Kimberly J Lake, DDS
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Dear New Patient:

We are happy that you have decided to choose our office to provide you with the top quality dental care that you deserve. Our goal is to create the best dental experience for you and your family, resulting in a healthy smile that will last a lifetime.

In order to be sure that your visit runs as smoothly and efficiently as possible, it would be helpful for you to fill out the enclosed new patient forms. Please bring these completed forms with you on the day of your visit. If for any reason you are unable to do so, please arrive 30 minutes before your scheduled appointment time in order to fill out these forms in office.

We are looking forward to meeting you at your scheduled visit.

Warm Regards,

The Team at Lake Family Dental

PLEASE PROVIDE OUR OFFICE WITH A COPY OF YOUR DRIVERS LICENSE AND DENTAL INSURANCE CARD

Lake Family Dental

Date:_____

Patient Information

Patient Name:_____ Preferred Name:_____

Sex: M / F Date of Birth:_____ SS#_____ Marital Status: S / M/ D

Cell Phone:_____ Alternate telephone #:_____

Home Address:_____

_____

Patient Employer:_____ Email Address:_____

Spouse's Name:_____ Phone #:_____

Emergency Contact:_____ Phone #:_____

How did you hear about our office? _____

Billing Information

(This section only needs to be filled out if patient is a minor or has a legal guardian)

Responsible Party:_____

Cell Phone:_____ Alternate telephone #:_____

SS#:_____ Date of Birth:_____

Mailing Address:_____

_____

Employer:_____ Email address:_____

Insurance Information

Name of Insured:_____ Date of Birth:_____

Employer:_____ SS#: _____

Insurance Company:_____ Phone #:_____

Group #:_____ Member ID:_____

Informed Consent for General Dentistry

I understand at my initial and subsequent visits, my care may require x-rays to complete my examination, diagnosis, and treatment planning. If I refuse the recommended x-rays, the staff may decline to treat me, as they would not have all the information needed for proper treatment planning. If I have recent x-rays from another dentist that I wish to use, it my sole responsibility to have them for the professional staff to review. I agree to cooperate with the staff if they advise me that copies of x-rays from another office are not of diagnostic quality and I need further x-rays in this office.

_____ _____

Signature of patient, parent, or guardian Date

Lake Family Dental Office and Financial Policies

We ask that you provide any/all insurance information to us prior to your first visit. While we do our very best to outline your insurance plan to you, ***it is ultimately your responsibility to know your insurance plan benefits and restrictions.*** Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. It is important to remember that your insurance policy is a contract ***between you and your insurance company.*** We will do everything possible to assist you in getting your claim paid; however, all charges incurred for your dental treatment are ***your sole financial responsibility.*** Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. **They are not a guarantee of payment to us.** We ask that you pay your co-payment, deductible, or any balances at the time services are rendered. If you are unable to pay your estimated portion at that time, we ask that you make prior financial arrangements with our billing representative.

As a courtesy, we will file your secondary insurance as needed. No refunds are issued until both insurance companies have settled claim(s), and our office has received full payment of benefits.

If you do not have dental insurance, by signing below you acknowledge that you understand you are responsible for payment in full at the time services are rendered.

If you have insurance, by signing below you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account.

By signing below, you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18% annual rate). **If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.** I acknowledge that I may be contacted for account servicing matters, including but not limited to collecting on my account should it become delinquent.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to Kimberly Lake, DDS and Lake Family Dental. In the event my insurance company pays a claim directly to me in the form of a check, I agree to notify Lake Family Dental upon receipt of the check and to sign over the check to Lake Family Dental in order to settle my account.

As a courtesy to other patients, all cancellations must be made at least 2 business days before any scheduled appointment. If cancellations occur after this time, your account may be charged a cancellation fee. If you fail to show up for your scheduled appointment, your account will be charged a "No-Show" fee.

By signing below, I acknowledge that I have read and understand Lake Family Dental's office and financial policies.

_____ _____

Signature Date

Medical History

YES	NO	
❑	❑	Are you under a physician's care now? Physician's Name: _____
❑	❑	Have you ever been hospitalized or had a major operation? _____
		_____
❑	❑	Has a physician recommended that you take antibiotics prior to dental treatment?
❑	❑	Do you use tobacco?
❑	❑	Do you grind your teeth?
❑	❑	Do you snore or has someone ever told you that you snore?

Women: Are you **❑Pregnant?** **❑Nursing?** **❑Taking oral contraceptives?**

Please list all medications you are currently taking:

_____
_____
_____

Are you allergic to any of the following? **(please circle)**

Aspirin	Penicillin	Clindamycin	Acrylic	Metal	Latex

Other: _____

Do you have or have you had any of the following? **(Please Circle)**

Heart Murmur	Diabetes	Sleep Apnea/ Snoring	Arthritis
Previous Heart Attacks	Cancer	Any Blood Disease	Any Liver Disease
Chest pain/ Angina	Stomach Disease	Intestinal Disease	Venereal Disease
High Blood Pressure	AIDS/ HIV+	Hepatitis	Epilepsy/ Seizures
Low Blood Pressure	Bleeding Problems	Kidney Disease/Dialysis	
Dry Mouth	Stroke	Thyroid Disease	Tuberculosis
Respiratory Disease	Autoimmune	History of fainting	
Developmental/ Behavioral Issues (ie: Autism/ Down Syndrome)	Other: _____ _____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date

Patient Consent for Use and Disclosure of Protected Health Information

_____ _____

Patient Name Date

My name and signature on this sheet indicate that I have been given the opportunity to review and request a copy of Lake Family Dental's Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative.

I hereby give my consent for Lake Family Dental to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO) including but not limited to phone calls, texts, and/or emails pertaining to insurance, appointment reminders, and patient statements.

_____

Signature of patient, parent or legal guardian

I hereby give my consent for Lake Family Dental to discuss my treatment recommendations, appointments, and account information with the following individuals:

_____ _____

_____ _____

_____

Patient Signature

For Minors: I authorize the following people to make treatment decisions on my behalf concerning my child.

_____ _____

_____ _____

_____

Signature of Parent or Legal Guardian

OralID™

Shine Light. Save Lives.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the Oral**ID**™ screening device into our office. The Oral**ID**™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the Oral**ID**™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the Oral**ID**™ to reduce the mortality of late stage detection.

Our office charges $_25_ per screening with the Oral**ID**.

☐ Yes, I request that your staff perform an examination with the Oral**ID**. I accept financial responsibility for this examination.

_____ _____ _____

Signature Name Date

☐ No, I prefer to not have this examination at this visit.

_____ _____ _____

Signature Name Date