TLC Dentistry

Patient Information Form

Thank you for choosing our dental practice. Please fill out this form as completely as you can. If you have any questions we will be glad to help.

(Please Print)

Name: _____ ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Rev. ☐Other: _____
First MI Last

Address: _____ Occupation: _____ ☐Male ☐Female

City_____ State_____ Zip_____ Home #(_____)_____

Employer _____ Work # (_____)_____Ext_____

Are you: ☐Minor ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated Mobile # (____)_____

SSN _____ DOB _____/_____/_____ Email: _____@_____

Driver's License #: _____ State _____

Spouse's Name: _____
First MI Last

Spouse's Occupation: _____ Work # (_____)_____Ext_____

Is patient a full time student? ☐No ☐Yes: Name of school:_____

Responsible Party (if different from above)

Name: _____
First MI Last

Address:_____

City_____ State_____ Zip_____

SSN _____ DOB _____/_____/_____

Your Preferences:

Do you prefer appointment reminders by: ☐Email ☐Phone ☐Text

Do you prefer to received calls from our office at: ☐Home ☐Work ☐Cell

Who may we thank for inviting you? _____

How would you like to be addressed by our team? _____

Insurance Information

MEDICAL INSURANCE:

Subscribers Name: _____ Relationship to patient: _____

DOB _____/_____/_____ Subscriber's SSN / ID# _____ / _____

Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE:

Subscribers Name: _____ Relationship to patient: _____

Address _____ City_____ State _____ Zip _____

DOB _____/_____/_____ Subscriber's SSN / ID# _____ / _____

Insurance Company _____ Group # _____ Effective Date _____/_____/_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐No ☐Yes If yes, please complete the following:

Subscribers Name: _____ Relationship to patient: _____

Address _____ City_____ State _____ Zip _____

DOB _____/_____/_____ Subscriber's SSN / ID# _____ / _____

Insurance Company _____ Group # _____ Effective Date _____/_____/_____

*X*_____ _____
Signature of Responsible Party *Date*

_____
Patient Name

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Financial and Privacy Information

Payment Options
We accept cash, personal checks, debit card, Master Card, Visa, Discover Card, and American Express. In addition, we offer excellent third party financial payment plans for balances over $500. Our office staff would be happy to provide you with more detailed information on this plan if you are interested.

Financial Consent
I understand that responsibility for payment of services provided in the office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 ½ % finance charge (18% annually) that will be applied to any balance over 60 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize TLC Dentistry (Philip J Lips, DDS, Inc) and the staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Returned Checks
In the event a check issued by you is returned, there will be a fee of $25 charged per incident. If a returned check is not paid within 30 days, you will be charged three times the amount of the check, up to $1500.00. California Civil Code, Chapter 522, Section 1719.

Acknowledgment of receipt of Notice of Privacy Practices
I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you have the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions of how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I have been informed of, and given the right to review and secure a copy of Dental Materials Fact Sheet dated October 2001 from TLC Dentistry

If you have any questions about the above information, please do not hesitate to ask us. We are here to serve you.
I have read the policies described in this form. I agree to abide by the terms outlined. I fully understand and accept my financial responsibilities,

*X*_____ _____
Signature of Responsible Party *Date*

_____
Patient Name

For Program Use Only
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refuses to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ *Other (please specify)*_____

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Medical History and Consent

Current Weight: _____ lbs. Height: _____ ft _____ in

Circle appropriate answer *(leave blank if you do not understand the question)*

Yes / No Are you being treated by a physician now? If **YES**,explain_____

Yes / No Have you gone to the hospital or emergency room or had a serious illness I the last three years?
If **YES**, explain_____

Yes / No Have you had any serious head or neck injuries? If **YES**, explain_____

Yes / No Are you taking any medications or supplements? If **YES**, please list _____

Yes / No Do you take or have you taken Phen-Fen or Redux?

Yes / No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

Yes / No Are you on a special diet? If **YES**, explain _____

Yes / No Do you use tobacco? If **YES**, How many packs per ☐day ☐week ☐month? _____

Yes / No Do you use **smokeless** tobacco?

Yes / No Do you consume alcoholic beverages? If **YES**, How many drinks per ☐day ☐week ☐month? _____

Yes / No Do you use recreational drugs?

Yes / No Have you ever had to pre-medicate with an antibiotic prior to dental treatment?

Women only *(Please circle Yes or No for each)*

Yes / No	Are you or could you be pregnant? If YES, what month? _____
Yes / No	Are you nursing?
Yes / No	Are you taking birth control pills?

Allergies

Yes / No	Aspirin	Yes / No	Codeine	Yes / No	Acrylic	Yes / No	Latex
Yes / No	Penicillin	Yes / No	Local Anesthetics	Yes / No	Metal	Yes / No	Sulfa Drugs
Yes / No	Other	If yes, please explain:					

Do you have, or have you had, any of the following? *(Please circle Yes or No for each)*

Yes / No	Aids / HIV	Yes / No	Cortisone Medicine	Yes / No	Hemophilia	Yes / No	Radiation Treatments
Yes / No	Alzheimer's Disease	Yes / No	Diabetes	Yes / No	Hepatitis A	Yes / No	Recent Weight Loss
Yes / No	Anaphalaxis	Yes / No	Drug Addiction	Yes / No	Hepatitis B or C	Yes / No	Renal Dialysis
Yes / No	Anemia	Yes / No	Easily Winded	Yes / No	Herpes	Yes / No	Rheumatic Fever
Yes / No	Angina	Yes / No	Emphysema	Yes / No	High Blood Pressure	Yes / No	Rheumatism
Yes / No	Arthritis / Gout	Yes / No	Epilepsy or Seizures	Yes / No	High Cholesterol	Yes / No	Scarlet Fever
Yes / No	Artificial Heart Valve	Yes / No	Excessive Bleeding	Yes / No	Hives or Rash	Yes / No	Shingles
Yes / No	Artificial Joint(s)	Yes / No	Excessive Thirst	Yes / No	Hypoglycemia	Yes / No	Sickle Cell Disease
Yes / No	Asthma	Yes / No	Fainting Spells / Dizziness	Yes / No	Irregular Heartbeat	Yes / No	Sinus Trouble
Yes / No	Blood Disease	Yes / No	Frequent Cough	Yes / No	Kidney Problems	Yes / No	Spina Bifida
Yes / No	Blood Transfusion	Yes / No	Frequent Diarrhea	Yes / No	Leukemia	Yes / No	Stomach / Intestinal Problems
Yes / No	Breathing Problem	Yes / No	Frequent Urination	Yes / No	Liver Disease	Yes / No	Stroke
Yes / No	Bruise Easily	Yes / No	Genital Herpes	Yes / No	Low Blood Pressure	Yes / No	Swelling of the Limbs
Yes / No	Cancer	Yes / No	Glaucoma	Yes / No	Lung Disease	Yes / No	Thyroid Disease
Yes / No	Chemotherapy	Yes / No	Hay Fever	Yes / No	Mitral Valve Prolapse	Yes / No	Tonsillitis

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Do you have, or have you had, any of the following? *(Continued)*							
Yes / No	Chest Pains	Yes / No	Heart Attack / Failure	Yes / No	Osteoporosis	Yes / No	Tuberculosis
Yes / No	Cold Sores / Fever Blisters	Yes / No	Heart Murmur	Yes / No	Pain in Jaw Joints	Yes / No	Ulcers
Yes / No	Congenital Heart Disorder	Yes / No	Heart Pacemaker	Yes / No	Parathyroid Disease	Yes / No	Venereal Disease
Yes / No	Convulsions	Yes / No	Heart Trouble / Disease	Yes / No	Psychiatric Care	Yes / No	Yellow Jaundice
Yes / No	Daytime Sleepiness	Yes / No	Morning Headaches	Yes / No	Sleep Apnea	Yes / No	Do you use a CPAP?
Yes / No	Do you Snore?	Yes / No	Teeth Grinding	Yes / No	Difficulty Swallowing	Yes / No	Difficulty Chewing
Yes / No	Orthodontics/ Invisalign	Yes / No	Dry Mouth	Yes / No	Bleeding Gums	Yes / No	Removable Teeth
Yes / No	Acid Reflux	Yes / No	GERD	Yes / No	Change in Hearing	Yes / No	Change in Vision

Have you ever had any serious illness not listed above? Yes / No If yes, explain _____

_____

_____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Physician's Name _____ Phone Number _____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes TLC Dentistry (Philip J Lips, DDS, Inc) to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize TLC Dentistry (Philip J Lips, DDS, Inc) to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that TLC Dentistry (Philip J Lips, DDS, Inc) choose and employ such assistance as deemed necessary. I understand that the use of local anethetics agents embodies certain risk and consent to their use as deemed appropriate by TLC Dentistry (Philip J Lips, DDS, Inc). To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

*X*_____ _____
Signature of Responsible Party *Date*

_____
Patient Name

_____ _____
Signature of Dentist Date

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Appointment Agreement

TLC Dentistry is dedicated to your quality care and is pleased to reserve your appointment time exclusively for you. We attempt to schedule appointments that are most convenient for you and that fit your personal schedule.

We respect our patients time and make every effort to remain on schedule. Some visits are more complicated than initially anticipated, and emergencies may arise that could possibly delay us. In such a case, every effort will be make to notify you beforehand.

Appointment commitments are taken very seriously at this office. Appointments are arranged at a time when you, our valued patient, have agreed to be available and we feel that we will have sufficient time to provide high-quality service. We reserve time, personnel and equipment for your specific needs and it is very important that you arrive at or before the agreed upon time.

We understand that there are unforeseen circumstances that cause reserved appointments to be missed with out 2 business days (48 hours) notice; we certainly want to make provisions for this within our policy. In order to make this provision, as well as to maintain the most efficient schedule for all our patients, our Appointment Policy is as follows:

- As a courtesy, our team attempts to confirm appointments one week before the scheduled date and time by the methods of voice, text, and email. If we do not hear from you, we will call you two days before the reserved time. If we do not hear back from you within 24 hours of your appointment, the reserved time may be canceled and given to the next patient in need of treatment.

- Patients who miss or reschedule their appointment without the required 2 business days (48 hours) notice will be required to supply us with a credit card to secure their rescheduled appointment. TLC Dentistry will not place any charges on the credit card, so long as the rescheduled appointment is honored.

- Patients who are late and/or miss more that two consecutive appointments without giving a minimum of 2 business days (48 hours) notice will incur a missed appointment fee of $50 and/or will be released from our care.

- Patients scheduled for appointments of 3 hours duration or longer must provide a minimum of 7 business days notice before rescheduling or canceling the appointment. Otherwise a $250 broken appointment fee will be assessed.

To avoid raising our dental fees and allow for all of our patients to reserve appointment times when desired, we find it necessary to implement this policy. Thank you for your understanding and respecting our time policy.

I have read the policies described in this form. I agree to abide by the terms outlined.

*X*_____ _____

Signature of Responsible Party *Date*

_____

Patient Name

_____

Relationship to patient

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