# DENTAL CARE of CLINTON, PLLC

Chart #:_____
FOR OFFICE USE ONLY

## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ (Cell) _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

**Have you had any of the following?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ☐Yes ☐No | Convulsions | ☐Yes ☐No | Heart Trouble/Disease | ☐Yes ☐No | Radiation Treatments | ☐Yes ☐No |
| Allergies | ☐Yes ☐No | Cortisone Medicine | ☐Yes ☐No | Hemophilia | ☐Yes ☐No | Recent Weight Loss | ☐Yes ☐No |
| Alzheimer's Disease | ☐Yes ☐No | Diabetes | ☐Yes ☐No | Hepatitis A | ☐Yes ☐No | Renal Dialysis | ☐Yes ☐No |
| Anaphylaxis | ☐Yes ☐No | Drug Addiction | ☐Yes ☐No | Hepatitis B or C | ☐Yes ☐No | Rheumatic Fever | ☐Yes ☐No |
| Anemia | ☐Yes ☐No | Easily Winded | ☐Yes ☐No | Herpes | ☐Yes ☐No | Rheumatism | ☐Yes ☐No |
| Angina | ☐Yes ☐No | Emphysema | ☐Yes ☐No | High Blood Pressure | ☐Yes ☐No | Scarlet Fever | ☐Yes ☐No |
| Arthritis/Gout | ☐Yes ☐No | Epilepsy or Seizures | ☐Yes ☐No | Hives or Rash | ☐Yes ☐No | Shingles | ☐Yes ☐No |
| Artificial Heart Valve | ☐Yes ☐No | Excessive Bleeding | ☐Yes ☐No | Hypoglycemia | ☐Yes ☐No | Sickle Cell Disease | ☐Yes ☐No |
| Artificial Joint | ☐Yes ☐No | Excessive Thirst | ☐Yes ☐No | Irregular Heartbeat | ☐Yes ☐No | Sinus Trouble | ☐Yes ☐No |
| Asthma | ☐Yes ☐No | Fainting Spells/Dizziness | ☐Yes ☐No | Kidney Problems | ☐Yes ☐No | Stomach Intestinal Disease | ☐Yes ☐No |
| Blood Disease | ☐Yes ☐No | Frequent Cough | ☐Yes ☐No | Leukemia | ☐Yes ☐No | Stroke | ☐Yes ☐No |
| Blood Transfusion | ☐Yes ☐No | Frequent Diarrhea | ☐Yes ☐No | Liver Disease | ☐Yes ☐No | Swelling of Limbs | ☐Yes ☐No |
| Breathing Problem | ☐Yes ☐No | Frequent Headaches | ☐Yes ☐No | Low Blood Pressure | ☐Yes ☐No | Thyroid Disease | ☐Yes ☐No |
| Bruise Easily | ☐Yes ☐No | Genital Herpes | ☐Yes ☐No | Lung Disease | ☐Yes ☐No | Tonsillitis | ☐Yes ☐No |
| Cancer | ☐Yes ☐No | Glaucoma | ☐Yes ☐No | Mitral Valve Prolapse | ☐Yes ☐No | Tuberculosis | ☐Yes ☐No |
| Chemotherapy | ☐Yes ☐No | Hay Fever | ☐Yes ☐No | Pain in Jaw Joints | ☐Yes ☐No | Tumors or Growths | ☐Yes ☐No |
| Chest Pains | ☐Yes ☐No | Heart Attack/Failure | ☐Yes ☐No | Parathyroid Disease | ☐Yes ☐No | Ulcers | ☐Yes ☐No |
| Cold Sores/Fever Blisters | ☐Yes ☐No | Heart Murmur | ☐Yes ☐No | Pregnant | ☐Yes ☐No | Venereal Disease | ☐Yes ☐No |
| Congenital Heart Disorder | ☐Yes ☐No | Heart Pace Maker | ☐Yes ☐No | Psychiatric Care | ☐Yes ☐No | Yellow Jaundice | ☐Yes ☐No |

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you use tobacco? ☐ Yes ☐ No
- Do you drink alcoholic beverages? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

## Insurance Information

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient _____
**Signature of guarantor of payment/responsible party**

## DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention?

_____

Do any of the following cause tooth discomfort? Hot____ Cold____ Sweets_____ Chewing_____

How often do you brush your teeth? _____ Floss? _____ Water Jet?_____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____Click or pop? _____

Can you chew on both sides of your mouth? _____Comfortably? _____

Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment (braces)? _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____

Do you have any missing teeth? _____Have they been replaced? _____

If so, how? Fixed bridge _____Removable Partial _____Full Denture _____Dental Implants _____

Are you comfortable/uncomfortable with the replacement? _____

Please describe_____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the results? _____

Have you ever had any unpleasant dental experiences?

_____

Signature _____

## FINANCIAL POLICY

1. It is customary to receive payment in full for services rendered at the time of the visit. The office accepts assignment on dental insurance (*) so long as insurance benefits are verified and the deductible or co-payment is paid at the time of the visit.
2. First time patients being treated on an emergency basis must pay in full at the time of service.
3. The office will accept cash, personal checks, Visa and MasterCard for all services rendered. A service charge of $30.00 will be assessed on all returned checks.
4. Third party financing is available through Care Credit. Please see the Receptionist for details.
5. The office will gladly accept dental insurance (*). Patients are responsible for the full amount. The Business Manager will estimate the benefits for services rendered, with any deductible and/or co-payments due at the time of service. The estimated co-payment is due on the day service is rendered. **Remember that these are estimates only.** Patients will be responsible for the difference between the actual payment and the fee. **If payment has not been received from the insurance within sixty days of the original filing, the patient will be asked to pay balance due and pursue reimbursement from their carrier.**
6. The office will assess account balances in excess of 90 days a monthly service charge of one half percent (1.5% per month or 18%annum) of the unpaid balance. **The office requires the patient to give at least 24-hour notice of any appointment that needs to be rescheduled or cancelled. We will allow you to reschedule a second appointment, if your first appointment was broken. If the second appointment is also broken, we will then charge a failed appointment fee of $50.00 and in order to receive another appointment we will require the patient portion of the service at the time the appointment is made.**

*I understand and agree to abide by the financial policy, and authorize payment directly to Dr. Neal Lehan of the insurance (*) benefits otherwise payable to me.*

_____ _____

Signature of Patient (Parent or Guardian if a Minor) Date

***INSURANCE EXCEPTION – THIS OFFICE DOES NOT ACCEPT "FEE SCHEDULE" INSURANCE FOR PAYMENT.**

---

## PRESCRIPTION/DRUG POLICY

Prescriptions will not be refilled after normal business hours, on holidays or weekends when the doctor on call does not have your records. This is for your safety and the safety of others. An early refill on your pain medicine will NOT be granted if you take more than the prescribed amount.
Prescription refills should be called into your pharmacy. Your pharmacy will then contact the office. It will take up to two working office days to refill a prescription.
Prescriptions will not be refilled if you have cancelled your last appointment, did not show for you last appointment, if you do not follow through with recommended medical treatment /testing, you have been discharged from the practice, or if you were to return only as needed (PRN). WE DO NOT PRACTICE PAIN MANAGEMENT.
Prescriptions that have been lost (or discarded) will not be refilled.
Prescriptions that have been stolen will not be refilled.
During the time of your care in this office, unless we have referred you to a pain management specialist, this office will be the ONLY SOURCE OF YOUR PAIN MEDICINE. You may still receive other medication (for an example, antibiotics.) from your family doctor, but only ONE doctor should be prescribing your pain medication at a time.
It is our legal duty to report to the authorities the name of a patient whom we believe may be taking, selling, or distributing narcotics or other medications illegally.
We reserve the right to terminate the doctor-patient relationship in the event of any breech in this policy by the patient.
I HAVE READ THE ABOVE POLICY AND AGREE TO THE TERMS

SIGNATURE_____ DATE_____

**Dental Care of Clinton**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgement****

**I, _____, have received a copy of this office's Notice of Privacy Practices.**

_____

**Please Print Name**

_____

**Signature**

_____

**Date**

---

**For Office Use Only**

---

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

- ○ **Individual refused to sign**
- ○ **Communications barriers prohibited obtaining the acknowledgement**
- ○ **An emergency situation prevented us from obtaining acknowledgement**
- ○ **Other (Please specify)**

_____

_____

_____