PATIENT INFORMATION

DOB: ______________

First Name: ______________________________ Last Name ______________________________ Preferred Name ______________________

Home Phone __________________________ Wireless # __________________________ Work Phone __________________________

Address _____________________________________ City ______________________________ State ______________ Zip __________

Email ____ SS Number ______________________________

In Case of an Emergency _____________________________________ In case of Emergency phone# ______________________________

Patient's Employer _____________________________________

Name of patient's medical doctor _____________________________________

Patient's pharmacy ______________________________

Whom may we thank you for referring you to our office? ____

Insurance Information:

If you have dental insurance please give your INSURANCE CARD to the front desk for a copy to be made.

Subscriber SSN or ID number for insurance purposes ____

You will be asked for a form of identification, please have your driver's license ready for a copy to be made.

MEDICAL HISTORY

Patient Name: ____________________ ____________________ ____________________
First Name Last Name DOB

Mark any medications that you are no longer taking and add any new ones.

☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________
☐ ____________________	☐ ____________________

Please Check YES or NO to all that apply

Y N
- ☐☐ Blood Transfusion
- ☐☐ High Cholesterol
- ☐☐ Abnormal Bleeding after Extractions
- ☐☐ Allergies- Seasonal
- ☐☐ Alzheimers
- ☐☐ COPD
- ☐☐ High Blood Pressure
- ☐☐ Low Blood Pressure
- ☐☐ Hepatitis or other Liver disease
- ☐☐ Heart Murmur or Mitral Valve Prolaspe
- ☐☐ Heart Valve Replacement

Y N
- ☐☐ Anxiety
- ☐☐ Depression
- ☐☐ Asthma
- ☐☐ Diabetes
- ☐☐ Aids or HIV Positive
- ☐☐ Mental Disorders
- ☐☐ Parkinson Disease
- ☐☐ Anticoagulants - Blood Thinner
- ☐☐ Do you smoke or use tobacco?
- ☐☐ Thyroid Disease
- ☐☐ Coronary artery disease

Y N
- ☐☐ Seizures
- ☐☐ Osteoporosis Injections or Medicatio
- ☐☐ Angina- Coronary Artery Disease
- ☐☐ Pacemaker or other Heart Appliance
- ☐☐ Kidney Disease
- ☐☐ Tuberculosis or COPD
- ☐☐ Post Traumatic Stress Disorder
- ☐☐ Autistic
- ☐☐ Auto Immune Disorder
- ☐☐ Alcoholism or Drug Abuse
- ☐☐ Kidney Dialysis

- ☐☐ Heart Conditions ____
- ☐☐ Women - Are you pregnant? Expected Delivery Date ____________________
- ☐☐ Transplant ____
- ☐☐ Cancer/Chemo or Radiation Treatment ____
- ☐☐ Artificial Joints

Are you allergic to, or reacted adversly to any of the following?

Y N
- ☐☐ Allergy to Aspirin
- ☐☐ Allergy to Sulfa
- ☐☐ Allergy to Ibuprofen/Advil
- ☐☐ Allergy to Acetaminophen/Tylenol

Y N
- ☐☐ Anesthetic
- ☐☐ Allergy to Latex Materials
- ☐☐ Allergy to Codeine
- ☐☐ Allergy to Penicillin
- ☐☐ Do you have any Metal Sensitivity

CONSENT FOR SERVICES

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICES

Payment options: Cash, Check, Mastercard, Visa, Discover, American Express, HSA cards, and Care credit

Patient's with insurance: The patient is responsible for the ESTIMATED non-covered portion of their balance for any procedures and/or deductables at the time of the service.

I GRANT MY PERMISSION TO YOU OR YOUR ASSIGNEE TO CONTACT ME AT HOME, CELL OR WORK TO DISCUSS MATTERS RELATED TO THIS FORM.

I HAVE READ THE ABOVE CONDITIONSOF TREATMENT AND PAYMENT OPTIONS AND AGREE TO THEIR CONTENT.

Signature of patient, parent, or guardian ____

Signature of guarantor of payment/responsible part____

APPOINTMENT CANCELLATION POLICY

We pride ourselves in providing the time for professional attention that each of our patients deserve. We will always respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is set aside exclusively for you.
When your appointment is made, a time reserved, your materials are ordered, and we make special arrangements to be ready for your visit. This is why we have a cancellation policy in place.
We ask that if you must reschedule your appointment, that you please provide us with at least a 24-hour notice. This courtesy makes it possible to give your reserved time slot to another patient.
There is a charge of $40.00 for not showing up for a scheduled appointment.
If you have any questions regarding this policy, please let our team know and we will be glad to clarify any questions you may have.
We thank you for choosing our office.

Signature that you have read Lufkin Family Dental cancellation policy____

Notice of Privacy Practices

OUR COMMENTMENT REGARDING YOUR PERSONAL HEALTH INFORMATION
Lufkin Family Dental is committed to maintaining and protecting the confidentiality of our patient's personal information. This notice describes how health information about you may be used and disclosed and how you can get access to this information. This notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to you as Protected Health Information [PHI]. This notice also describes the privacy rights you have and how you can excerise those rights. Please review it carefully.

If you have any questions about this notice, please contact Angela Adams at 936-634-5012 or email at info@lufkinfamilydental.com.

OUR OBLIGATIONS:

1. Maintain the privacy of protected health information
2. Give you this notice of our legal duties and privacy practices regarding health information about you.
3. Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you. We will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

For Treatment: For example, we may disclose health information to doctors, nurses, technicians or other personnel, including people outside our office who are involved in your medical care.
For Payment: We may disclose health information so that we or others may bill and receive payment from you, an insurance company or third party for the treatment and services that you received.
Appointment Reminders: Treatment Alternatives and Health Related Benefits and Services: We may use and disclose health information to contact you to remind you that you have an appointment with us. We may also use and disclose health information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
Individuals Involved in Your Care or Payment for your care: When appropriate, we may share health information with a person who is involved in your medical care or payment for your care, such as a family member or close friend. We may notify your family about your location or general condition.

I have received [or have been offered] a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment and health care operation purposes.

Patient Signature: ____