LEXINGTON
Family Dental

Laura Dixon, DMD
Robert Cronk, DMD

Patient Information

Patient Name: ______________________________ Date of Birth: __________
(First) (MI) (Last)

Address: ______________________ City: ______________ State: ______ Zip: ________

Social Security #: ______________________ Please select one: ☐ Male ☐ Female Age: ________

Patient Employer/School: ______________ Occupation: __________ Email: ______________

Home: (_____)____________ Work: (_____)____________ Cell: (_____)____________

Best time to reach you is: ____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name: ______________________________ Relationship: ______________________

Home: (_____)____________ Work: (_____)____________ Cell: (_____)____________

Please Select One: ☐ Married ☐ Divorced ☐ Single ☐ Minor ☐ Widowed

Spouse Name: ______________________________ Spouse DOB: __________
(First) (MI) (Last)

Spouse Social Security #: ______________________ Spouse Employer: ______________

How did you hear about us? ____

If referred, who may we thank for referring you? ______________________________

Responsible Party Information

If the Patient is the responsible party, please check here, skip this section and continue onto Primary Dental Insurance

☐ I am financially responsible for my account

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ both ☐ neither-not applicable

Name: ______________ ______________ _____ ______________
(Last) (First) (MI) (Preferred Name)

Title: ________ **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ **SS#:** _____ - ___ - _________ **DL#:** ______________

Email Address: ______________________ **Best time to call:** ______________

Phone: __________ __________ __________ _____ __________ __________
(Home) (Mobile) (Work) (Ext.) (Fax) (Other)

Address: ______________________ ______________________
(Address 1) (Address 2)

______________________ __________ __________
(City) (State) (Zip Code)

Dental Insurance

Insurance Company: ______________________ Group # ______________

Who is responsible for this account? ______________________ Union or Local # __________

Subscriber's Name: ______________________ Date of Birth: __________

Social Security #: ______________________ Relationship to patient: ______________

Employer: ______________________ Work #: (_____) ______________

Employer Address: ______________________ City: __________ State: ______ Zip: ________

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Dental History

Reason for today's visit: ______________________________ Date of last dental visit? ______________

Former Dentist: ____________________ Phone: (____)____________ Date of last dental X-ray? ______________

Check if you have or have had a problem with any of the following:

- ☐ Bad Breath
- ☐ Clicking or poppping jaw
- ☐ Grinding teeth
- ☐ Sensitivity to cold or hot
- ☐ Bleeding Gums
- ☐ Food collecting between teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to sweets
- ☐ Sores or growths in your mouth

How often do you floss? ____________ How often do you brush? ______________

Medical History

Physician's Name: ______________________________ Date of last visit? ______________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (defenfluramine). ☐ Yes ☐ No

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, explain: ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: ______________________

(Women only) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Check if you have or have had problems with any of the following: (Please check all that apply.)

- ☐ Anemia
- ☐ Arthiritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Veneral Disease

List of medications you are currently taking: ____

____

Allergies:

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Iodine
- ☐ Barbiurates (Sleeping Pills)
- ☐ None
- ☐ Latex
- ☐ Codeine
- ☐ Sulfa
- ☐ Penicillin

Other ______________________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

______________________________________ ______________

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

______________________________________ ______________

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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Caries Risk Assessment Survey

High **Moderate** **Low**

Patient's Name: ______________________ Age:________ Date:________________

Many of our patients express concern over having cavities. In fact, dental caries remains the most common threat to early childhood oral health. However, children are not the only ones at risk but many adults also face higher risk due to medical issues, dietary habits, and side effects from common medications.

The goal of this assessment form is to help us determine what your personal risk status is for decay. Please fill out the "Patient Use" section to the best of your ability. With this information, we will be able to discuss the appropriate preventive measures available to you to reduce your risk for cavities.

Risk Factors (Patient Use)

Do you notice plaque build-up on your teeth between brushing? ☐ Yes ☐ No

Do you take medication daily? If yes, how many? ☐ Yes ____________ ☐ No

Do you feel like you have dry mouth at any time of the day? ☐ Yes ☐ No

Do you drink liquids other than water more than 2 times daily between meals? ☐ Yes ☐ No

Do you snack daily between meals? ☐ Yes ☐ No

Do you have oral appliances present? ☐ Yes ☐ No

Do any of these health concerns apply to you? (check all that apply) ☐ Frequent Tobacco Use ☐ Diabetes ☐ Recreational Drug Use ☐ Acid Reflux ☐ Bulimia ☐ Sjogren's Syndrome ☐ Head/Neck Radiation

Professional Assessment (Clinician Use)

Plaque/Calculus	Generalized	Localized	Minimal
New/Progressing Visible Cavitation	Yes		No
New/Progressing Radiographic Radiluncencies	Yes		No
Exposed Roots	Yes		No
Deep Pits of Fissures	Yes		No
White Spot Lesions	Yes		No
Cavity Diagnosed in the Last 3 Years	Yes		No
Uses Fluoride Toothpaste or Mouthwash	Yes		No
Drinks Fluoridated Water	Yes		No
Supplements Xylitol Gum/Mint	Yes		No

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NOTICE OF PRIVACY/CONSENT FORM

I, ____, understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up amount the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain payments from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that my medical records including x-rays may be sent via protected or encrypted email or mail.

I understand that if I have a concern about the privacy of my medical records, I can contact Lexington Family Dental, or concerns can be submitted directly to the United States Department of Health and Human Services.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I give the staff of Lexington Family Dental permission to contact me by the following methods:

_______ Call me, including leaving a message on my voicemail or answering machine.

_______Send emails.

_______Send texts.

_______ Send post cards.

____ Signature of Patient, Parent, Guardian, or Personal Representative

________________ Date

____ Please print name of Patient, Parent, Guardian, or Personal Representative

________________ Relationship to Patient

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Financial & Insurance Policy

Please understand that the payment of your bill is considered part of your treatment, and we expect full payment at the time of service. We are in network with Medicaid and most other insurance companies. We accept cash, checks, MasterCard, Visa, and Care Credit. Patients under the age of 18 must have an adult (guardian) above the age of 21 accompany them, and the guardian is responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made to make payments.

Each of the following is a statement of our financial & insurance policy, which is required to be read, initialed and signed prior to any treatment. Please initial below in agreeance to the following statements before signing:

____ I understand that payment is due at the time of services rendered, and I assume full responsibility for the bill incurred, including anything not covered by my insurance provider.
____ I understand that the estimate given is not guaranteed to be the exact amount, since benefits cannot be determinted until claims are filed.
____ I understand that dentistry is not an exact science and success cannot be guaranteed.
____ I understand that in the event of a returned check, a $35.00 insufficient funds fee will be assessed to my account.
____ I understand that if my account becomes 30 days past due, it will be subject to a 1.5% fee charged to my account.
____ I understand that if I do not make a payment toward my account within 90 days, I will be sent to collections and accrue a collections fee totaling up to 50% of the remaining balance on the account at the time of default.
____ I understand that if this account goes into default, I will be responsible for all court costs, attorney's fees, and any other associated fees.
____ I understand that it is my responsibility to provide accurate and up-to-date dental/medical insurance information.

In certain circumstances, insurance companies may send payment directly to the patient. In such cases, the patient agrees to endorse and send the check to Lexington Family Dental. If the patient deposits the check refunded from the insurance company into a personal account, the patient agrees to send a personal check for the equivalent amount to Lexington Family Dental within 10 days of the deposit.

Assignment of Benefits
I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance, and any other health/medical plan, to issue payment directly to **Lexington Family Dental.** ________

Authorization to Release Information
I hereby authorize **Lexington Family Dental** to: (1) release any information necessary to the insurance carrier regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing. ________

I, ________________________, authorize **Lexington Family Dental** and affiliated associates and employees to perform any procedures deemed necessary during my treatment.

I have read the above financial & insurance policy. I understand and agree to the terms stated above.

X______________________________________
Signature of Patient or Responsbile Party

Today's Date: ___________________

X______________________________________
Name Printed of Patient or Responsible Party

**All appointments must be canceled 24 hours before the scheduled appointment or a $25.00 no show fee will be added to the patient's account.*
**This will serve as the responsible party's signature on file for the purpose of administering insurance benefits.*