

Lemons Dental Esthetics

Cosmetic and Family Dentistry

Patient Information

Patient Name: _____ Date: _____

Male Female

 Married Single Child Other _____

Social Security #: _____ Birth Date: _____

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

E-mail Address _____

Address: _____
Street Apartment #

_____ City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Do you grind your teeth excessively? _____

Do you experience pain, popping, or clicking noises in your Jaw Joints (TMJ) ? _____

Is there anything you would change about your smile? _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergy Codeine | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergy _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies Penicillin | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes type I / type II | <input type="checkbox"/> Rheumatic Fever | |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |

• 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: _____

• Are you currently taking any medications ? _____ Please List _____

• Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

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 doctor at the next appointment without fail.

 Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another Patient Dental Specialist
 Sign Flyer Newspaper Other _____

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

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Dental Insurance

Primary

Name of Insured: _____ ID# _____
Last First MI

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

Insured's Employer Name _____

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

Insurance Plan Name and Address: _____

Insurance Plan Phone Number: _____

Consent for Services

As a condition of your treatment by our office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost 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 by cash or credit card at the time the services are performed.

Patients who carry traditional dental insurance plans need only pay their estimated patient portion at the time services are rendered. This office will submit insurance claims electronically, and assist in obtaining collections from the insurance company. However, the patient is financially responsible for all dental services rendered.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 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 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 shall 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 agree to their content.

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