



PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Employer: _____
 Cellular: _____ Okay to Text appointment reminder.
 E-Mail: _____ I would like to receive correspondence via e-mail: Y N
 Birth Date: ____/____/____ SSN: _____-____-____ Marital Status: _____
 Emergency Contact: _____ Phone: _____ Relationship: _____

DENTAL HISTORY:

What is the reason of your visit today? _____

Are you experiencing pain or discomfort at this time? Yes No Date started: _____

Are you happy with the appearance of your teeth? Yes No Do you clench or grind your teeth? Yes No

Are you able to eat and chew food satisfactorily? Yes No Does your jaw click or pop? Yes No

Would you like to make your teeth Whiter? Yes No Do your gums bleed or feel tender? Yes No

Do you have headaches, earaches or neck pain? Yes No Have you ever had gum treatment? Yes No

Do you feel your breath offensive at times? Yes No Have you lost or removed any teeth? Yes No

Do your teeth feel loose or separating? Yes No Have they been replaced? Yes No

Does food get caught between your teeth? Yes No Fixed Bridge Date placed: _____

Difficulty opening or closing your mouth? Yes No Removable Partial Date placed: _____

Difficulty in chewing on either side? Yes No Full Denture Date placed: _____

Are your teeth sensitive to Hot or Cold Yes No Are your teeth sensitive to sweets Yes No

Date of last dental visit:	Date of last cleaning:	Last full mouth x-rays:	Do you use dental floss?

How often are your hygiene visits: 3 months 4 months 6 months 1 year

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

I give my consent to any advisable and necessary dental procedures, medication or anesthetic to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. I understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment, and its fee. To the best of my knowledge the information provided on this form is accurate.

All x-rays taken at no charge is the property of Lake Quality Dental.
There will be a \$55.00 transfer fee to send them to another office or to you.

Signature of Patient: _____ Date: _____

Signature of Doctor: _____ Date: _____

MEDICAL HISTORY

Patient name: _____ Birth Date: _____

Primary Care Physician: _____ Physician's Phone: _____

Pharmacy: _____ Location: _____ Telephone: _____

Have you ever had to pre-medicate with antibiotics prior to dental treatment? Yes No Type: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you on a special diet? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, how much?: _____ Do you use controlled substances? Yes No

WOMEN

Are you Pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Please be advised that antibiotics may reduce the effectiveness of oral contraceptives. Please consult a physician if antibiotics is prescribed.
Signature of acknowledgement: _____ **Date:** _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Metal Erythromycin Sulfa drugs
 Local Anesthetic Tetracycline Lidocaine Latex Other: If yes, please explain: _____

Please list all your prescription and over-the-counter medication you are taking. Please include herbal or natural supplements.

Are you taking any medication for osteoporosis? FOSAMAX _____

Please check all that applies:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach Intestinal Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting spells / Dizziness | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors of Growths |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Atrial fibrillation |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Renal Dialysis | |
| | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | |

All Payments are expected to pay in Cash, Check or Credit Card the day the service is rendered, unless arrangements are made in advance.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature: _____ Date: _____

**Lake Quality
Dental**



Dr. Helene P. Ta, DDS
1503 Buenos Aires Blvd., Ste 125
Lady Lake FL 32159
Phone: (352) 753-5838 Fax: (352) 391-5837

HIPPA: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

“You may refuse to sign this Acknowledgement”

I, _____, have read and seen a copy of this office’s notice of privacy practice.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because: _____ Individual refuse to sign _____ Communication barriers prohibited obtaining the acknowledgement _____ An emergency situation prevented us from obtaining acknowledgement _____ Other (Please specify)

DENTAL INSURANCE INFORMATION ONLY:

Please give your Insurance card and Picture ID to the receptionist to copy for your file.

Whenever possible, we will try to anticipate all cost up front so you may plan your financial obligations. However, sometimes additional material or procedures are necessary during treatment which may result in additional charges.

You are responsible for balances on your account if changes occur. As a courtesy to you, we will submit the claims to your Primary Insurance Company and you will be responsible for any additional secondary Insurance Claims.

We DO NOT GUARANTEE Insurance benefits OR payments.

The Insurance is an estimate of payment expected and not a guarantee of payment and Lake Quality Dental is not responsible for any amounts not paid by your Insurance and it is the patients’ responsibility to follow up on their Insurance.

Patient acknowledge, he/she is fully responsible for the total charges provided by Lake Quality Dental.

→ Patient signature: _____ Date: _____

Name of Insured: _____ Relationship to Insured: ___ Self ___ Spouse

Insures SSN: _____ Insured Birth Date: _____

Employer: _____ Retired from: _____

Insurance Company: _____ Group Number: _____

Insurance Address: _____ City: _____ State: ___ Zip: _____

Insurance Telephone Number: _____

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LAKE QUALITY DENTAL, INC

Financial Agreement

Professional services are rendered and charged to you, not the insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility. In order to honor any insurance benefits, you must provide insurance identification.

All deductibles and fee amounts not covered by insurance are due at the time of treatment. The office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. We will file your claim once. You will receive a statement of your account balance shows an amount due, regardless of insurance expectations. If at the end of 60 days, your insurance company has not paid, you are responsible for the entire balance. Upon request, we will supply you with a copy of the claim, so you can resubmit. **Initial** _____

Office Fees:

If you present a check for insufficient funds, or place a stop payment on an issued check, you will be charged a \$50 fee for processing and your checks will no longer be honored here.

PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED. WE ACCEPT CASH, CHECK, CREDIT CARDS AND MOST INSURANCE PLANS. **Initial** _____

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change reserved dental appointments.

Broken and missed appointments create scheduling problems for other patients as well as the practice. If you find that you must change your appointment, we require a minimum 24 hour notice, so that we may accommodate another patient. A charge in the amount of \$50.00 will be applied for broken/ missed appointments without 24 hours advance notice.

Thank you for your cooperation in this matter. **Initial** _____

We will charge 1.5% monthly (18% annual) interest on account balances over 60 days. If your account balance is not cleared after 90 days, your account will be turned over to a collection agency and will be subject to additional fines/charges. **Initial** _____

I HAVE READ AND UNDERSTAND THE STATEMENT LISTED ABOVE.

SIGNED: _____ DATE: _____

PRINTED NAME: _____

Thank you for choosing our practice. We appreciate the trust you have placed in us.