Lake Forest Dental Associates

Thank you for selecting Lake Forest Dental Associates as your dental healthcare team! We will strive to provide you with the best possible care for all our patients. To help us meet your healthcare needs, please complete all pages of these patient forms completely and in ink. If you have any questions or need assistance, please ask us - we are happy to help.

Date _____

Patient Information

First Name _____ Last _____ Middle Initial _____

Preferred Name _____ SSN _____ DOB _____

Address _____
Street City State Zip Code

Home Ph. _____ Work Ph. _____ Cell Ph. _____

Email _____ ☐ I would like to receive email correspondences
☐ I would like to receive text messages

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Whom may we thank for referring you? _____

If student, name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

If you are completing this form for another person, what is your relationship to that person? _____

Person to contact in case of an emergency: _____ Phone _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids?	☐	☐
3. Are your teeth sensitive to sweets?	☐	☐
4. Do any of your teeth hurt or are you experiencing pain?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Have you ever experienced any of the following:		
Problems with your jaw	☐	☐
Joint Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you ever had prolonged bleeding following an extraction?	☐	☐
11. Have you had orthodontic treatment?	☐	☐
12. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
13. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
14. Is there anything that concerns you about dental treatment?	☐	☐
15) Do you have any dental anxiety?	☐	☐
16) Are you interested in any sedation (Ex: Laughing gas or Halcion)?	☐	☐

Patient Name:_____ DOB:_____

Patient Medical History

Physician_____ Name of Practice _____

Office Ph. _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical procedure or serious illness within the last 5 years?	☐	☐
If yes, please explain: _____		
3. Do you use tobacco?	☐	☐
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, please list: _____		
5. Are you allergic to or made sick by penicillin, aspirin, codeine, erythromycin, valium, tetracycline, any other drugs, or medications?	☐	☐
If yes, please explain: _____		
6. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following?

- ☐ Heart Attack/Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Cardiac Pacemaker
- ☐ Artificial Heart Valve
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Anemia
- ☐ Fainting/Seizures
- ☐ Epilepsy/Convulsion
- ☐ Asthma/Respiratory Problems
- ☐ Emphysema
- ☐ Sinus Trouble
- ☐ Glaucoma
- ☐ Thyroid Problems
- ☐ Tuberculosis (T.B.)
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Hepatitis/Liver Disease
- ☐ Immune System Disorder (incl. AIDS, HIV, ARC)
- ☐ Stomach Problems/Ulcer
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Cancer/Leukemia
- ☐ Radiation
- ☐ Chemotherapy
- ☐ Sleep Apnea/Snoring
- ☐ Psychiatric Treatment
- ☐ Eating Disorder
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Sexually Transmitted Disease
- ☐ Latex Sensitivity
- ☐ Allergic Reaction to Oral Anesthetic

- Do you have any disease, condition or problem not listed above that we should know about? ☐Yes ☐ No

If yes, please explain:_____

_____

Have you ever taken any of the following medications?

- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Bonefos/Loron
- ☐ Didronel
- ☐ Fosamax
- ☐ Reclast
- ☐ Skelid
- ☐ Zometa
- ☐ Arixtra
- ☐ Coumadin/Warfarin
- ☐ Eliquis
- ☐ Fragmin
- ☐ Lovenox
- ☐ Pradaxa
- ☐ Xarelto

Authorization and Release

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 medical status. I further authorize the release of any additional medical information as required for diagnosis and oral health treatment to Razdolsky Tincher DDS LLC, DBA, Lake Forest Dental Associates.

X_____ _____

Signature of patient (or parent if minor) Date

Patient Name:_____ DOB:_____

Insurance Information

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING

Employer_____ Insurance Co._____

Name of insured _____ Relationship to patient _____

Insured DOB _____ SSN _____

DO YOU HAVE SECONDARY DENTAL INSURANCE COVERAGE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING

Employer_____ Insurance Co._____

Name of insured _____ Relationship to patient _____

Insured DOB _____ SSN _____

DO YOU HAVE MEDICAL INSURANCE COVERAGE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING

Employer_____ Insurance Co._____

Name of insured _____ Relationship to patient _____

Insured DOB _____ SSN _____

Responsible Party *(Person responsible for account)*

Relationship to patient _____

First _____ Last _____ Middle Initial _____

Address *(if different)* _____
Street City State Zip Code

SSN _____ Home Phone_____ Work Phone_____

Is this person currently a patient in this office? ☐ Yes ☐ No

Broken Appointment Policy

A **policy** has been secured for patients who make **appointments** but fail to show up or decline to give adequate notice of cancellation, rescheduling or no show. Our practice reserves the right to charge for any reschedules, cancellations or no shows that have not given ***24 hours advance notice***. We understand that there are unforeseen circumstances that may occur that cause reserved appointments to be missed without 24 hours advance notice. In these circumstances, it will be at the discretion of the Doctors if a charge is appropriate at the time of fee application.

CANCELLATION & RESCHEDULING OF ANY 1HR+ APPOINTMENT:
In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment on the original scheduled time and date. This time will be given to someone who is in urgent need of treatment. Any appointment(s) that are 1 hour in appointment length that are not rescheduled or canceled 24 hours in-advance may be subject to a $50 late reschedule/cancellation fee. Any appointment(s) that are 2 hours in appointment length that are not rescheduled or canceled 24 hours in-advance may be subject to a $75 late reschedule/cancellation fee.

NO SHOW POLICY:
A no show is an appointment that was not canceled in-advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will therefore result in a ***$25 fee*** for every half hour of scheduled appointment time.

Acknowledgment and acceptance of appointment policy by responsible party required.

I hereby authorize the release of any information regarding diagnosis and treatment to third party payors, and request that my insurance company reimburse Razdolsky Tincher DDS LLC, DBA, Lake Forest Dental Associates directly for services rendered on my or my child's behalf.

Print Name _____ Signature_____ Date _____

Lake Forest Dental Associates

Notice of Privacy Practices

This Notice of Privacy Practices contains information regarding HIPAA (Health Insurance Portability and Accountability Act of 1996). It describes how medical and dental information about you may be used and disclosed.

TREATMENT

We will use and disclose your dental health information in order to provide, coordinate and or manage your dental health care. This includes disclosure of your dental history to other providers involved in your care.

PAYMENT

Disclosure of information diagnosis and procedures performed in your service to obtain insurance payment for services. This can also include information for work or accident related injuries rendered.

APPOINTMENT REMINDERS

Disclosure of protected information may be used to contact you in reminder call s of scheduled appointments or treatments. This information may also be disclosed to a family member, relative, or any other person you authorize.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me or obtaining payment for my care. This authorization provides that the Practice may release clinical information related to my diagnosis and treatment, which may be required by my insurance company or its designated agent.

Name (Please Print) _____

Signature _____ Date _____

Authorized Person (relationship to patient) _____

Patient unable to sign. Verbal consent given. (Reason) _____

cc: Patient File

Dr. Laniel Razdolsky
Dr. Monika Tincher

Lake Forest Dental Associates

Restorative • Cosmetic • Implant Dentistry

Patient Smile Evaluation Form

Patient Name: _____ Date: _____

This patient evaluation is designed to aid in our diagnosis and treatment of your esthetic concerns and get you closer to the smile you've always wanted. Please hold a mirror 12" to 14" from your face and smile to show your teeth. Take the time to observe your teeth carefully and respond below to the following questions.

Do you like the appearance of your teeth when you smile?	☐ Yes	☐ No
Do you dislike the color of your teeth?	☐ Yes	☐ No
Are your teeth crowded, crooked or out of alignment?	☐ Yes	☐ No
Do you have spaces between your teeth that bother you?	☐ Yes	☐ No
Do you have chips or uneven edges on your teeth?	☐ Yes	☐ No
Do you feel that your teeth are too long or too short?	☐ Yes	☐ No
Do you have dark silver/mercury fillings that show when you smile?	☐ Yes	☐ No
Do you have existing crowns or dental work you consider unattractive?	☐ Yes	☐ No
Are you self-conscious of your teeth and / or smile?	☐ Yes	☐ No
Do you avoid smiling when you have your picture taken?	☐ Yes	☐ No
Would you like to improve your existing smile?	☐ Yes	☐ No
Do you wish you had a "new smile"?	☐ Yes	☐ No
Has anyone ever suggested that you should have something done with your teeth or smile?	☐ Yes	☐ No

What would you like to change most about the appearance of your teeth?

_____

_____

_____

Place a checkmark next to any/all of the following concerns you may have regarding treatment that could improve your smile:

- ☐ Fear of treatment
- ☐ Time of treatment concerns
- ☐ Financial Concerns
- ☐ Distance to office
- ☐ Not understanding treatment
- ☐ Embarrassment
- ☐ Other: _____

Additional Comments:

_____

_____

_____