Lake Mary
Family Dentistry

Medical History and Background

Today's Date _____

Last Name _____ First Name _____ MI _____

Do you currently have a personal physician? _____ Yes _____ No Do you have an annual physical? _____ Yes _____ No

If you have a personal physician: Physician's Name _____ Phone Number _____

Are you currently receiving ongoing treatment for any conditions (diabetes, high blood pressure, etc)? _____

Are you currently taking any medications? _____ Yes _____ No Are you currently taking any herbal supplements? _____ Yes _____ No

Are you currently taking:

"Blood Thinners"
Aspirin □ Yes □ No
Coumadin (Warfarin) □ Yes □ No
Plavix (Clopidogrel) □ Yes □ No
Xarelto (Rivaroxaban) □ Yes □ No
Other _____

Anti-Inflamatory
Prednisone □ Yes □ No

Osteoporosis / Bisphosphonates
Actonel □ Yes □ No
Aredia □ Yes □ No
Boniva □ Yes □ No
Fosamax □ Yes □ No
Reclast □ Yes □ No
Aometa □ Yes □ No
Other _____

Diabetes
Insulin □ Yes □ No
Metformin □ Yes □ No
Other _____

Herbal Supplements
Fish Oil □ Yes □ No

Please list any additional medications (prescription or over the counter) or herbal supplements currently taking: _____

_____

Please list any surgeries, operations or hospitalizations: _____

Please indicate if you have or have had any of the following:

Cancer
Type _____
□ Chemotherapy
□ Radiation Therapy

Cardiovascular
□ Angina (Chest Pain)
□ Artificial Heart Valve
□ Heart Conditions
  □ Heart Attack
    Date _____ / _____
□ Heart Surgery
□ High / Low Blood Pressure
□ Mitral Valve Prolapse
□ Pacemaker
□ Rheumatic Fever
□ Scarlet Fever
□ Stroke

Endocrinology
□ Diabetes Type I / II (Circle)
□ Hepatitis A / B / C (Circle)
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Thyroid Disease

Gastrointestinal
□ Ulcers (Stomach)
□ Gastrointestinal Disease

Hematologic / Lymphatic
□ Anemia
□ Blood Disorders
□ Bruise Easily
□ Excessive Bleeding

Musculoskeletal
□ Arthritis
□ Artificial Joints
□ Jaw Joint Pain
□ Rheumatoid Arthritis

Neurological
□ Anxiety
□ Depression
□ Dizziness
□ Drug / Alcohol Addiction
  Type _____
□ Fainting
□ Seizures
□ Psychiatric Illness

Respiratory
□ Asthma
□ Emphysema
□ Respiratory Problems
□ Sinus Problems
□ Sleep Apnea
□ Tuberculosis

Viral Infections
□ AIDS
□ HIV Positive
□ HPV

Women
□ Currently Pregnant
□ Nursing

Medical Allergies

□ Antibiotics (Penicillin / Amoxicillin / Clindamycin) List _____
_____

□ Opioids (Percocet, Oxycodone, Tylenol 3) List _____
_____

□ Latex
□ Local Anesthetics
□ NSAIDs

Other Allergies: _____

CONSENT:
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the doctor and the office of any changes in my medical status.

_____ _____ _____ _____
Signature of Patient / Legal Guardian Print Name Date Dentist Signature

1325 S. International Parkway, Suite 1201
Lake Mary, Florida 32746
www.LakeMaryFamilyDentistry.com
email: office@lakemaryfamilydentistry.com
Phone: (407) 862-3344
Fax: (407) 862-3374

Lake Mary
Family Dentistry

Financial Policy

Last Name _____ First Name _____ MI _____

Payment Options:
At Lake Mary Family Dentistry, we believe you deserve the best care. We thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, as well as mobile payment services such as Apple Pay.

Lake Mary Family Dentistry also partners with CareCredit to provide additional financing options. If you are interested in utilizing CareCredit, please inform the office. Additionally, CareCredit information can be found at www.CareCredit.com or (800) 365-8295.

Please note: Returned checks will be subject to a $35.00 NSF fee. Additionally, in the case it becomes necessary for our office to enlist a collection service and / or legal assistance, you will be responsible for any collection and / or legal charges up to 35%.

Insurance Information:
We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. If any changes occur in your dental coverage, please inform the office.

Dental benefit plans are meant to assist employees with their dental health. Insurance plans rarely, if ever, pay for the entirety of your dental care.

As a courtesy to patients, we will help process all in-network insurance claims. We will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimate. Again, the estimated portion is based on the most current information the office has available, but it is ONLY AN ESTIMATE. Your insurance company and your plan will ultimately determine the amount paid. If the insurance carrier has not made payment within 60 days, we will request that the patient contact their insurance company directly to ensure that payment is expected. If the payment has not been received in 90 days, Lake Mary Family Dentistry reserves the right to request the payment in full for services directly from the patient and allow the patient to collect the remaining insurance funds.

On occasion, Lake Mary Family Dentistry will file a "Pre-Treatment Estimate" with the insurance company prior to treatment as a courtesy to estimate the insurance portion. The estimate is not a **guarantee of coverage**, nor a binding agreement with the insurance company. This will also delay treatment and is usually not recommended.

We request that you sign this form and any other needed documents required by your insurance company. This form will instruct your insurance company to make payment directly to the office if needed.

With in-network insurance transactions, we ask that you pay the deductible and co-payment, the estimated amount, not covered by your insurance company at the time of treatment.

We will fully cooperate with the requests and regulations of your insurance company that we may assist in the claim being paid. Our office, will not enter into a dispute with the insurance company over a claim.

Cancellation Fee:
A specific amount of time is reserved for patients when an appointment is made and we strongly encourage all patients to keep their appointments. If an appointment must be changed, we require at least a **72 hour notice to avoid a $50 cancellation fee**. We will reach out to confirm your appointment at least three days prior to the appointment to confirm. We kindly ask to call back to confirm the appointment.

CONSENT:
I have read, understand and agree to the above terms and conditions. If in-network, I authorize my insurance company to pay my dental benefits directly to Lake Mary Family Dentistry. I understand that the responsibility for payment of dental treatment for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, collection charge and / or attorney fee may be added to any overdue balance. By signing below, you are authorizing Lake Mary Family Dentistry to call you at any number you provide, including calls to mobile / cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and / or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____ _____
Signature of Patient / Legal Guardian | Print Name | Date

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Email and Text Messaging Consent Form

We are happy to provide our patients with the option to participate in our online patient communication system. Some of the features include:

1. REQUEST APPOINTMENTS VIA EMAIL/TEXT
2. CONFIRM APPOINTMENTS VIA EMAIL/TEXT
3. RECEIVE TEXT MESSAGE APPOINTMENT REMINDERS
4. RECEIVE NOTIFICATONS OF EVENTS AND PROMOTIONS

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment.

We will use the minimum necessary amount of protected health information in any communication.

PLEASE MARK THE FOLLOWING:

| I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

My email address is: _____

| I consent to receiving appointment reminders, events, and promotions via email or text. I understand I can withdraw my consent at any time.

Text Cell #_____

| l do not consent to receiving any information via email or text. I understand that I can change my mind and provide consent later.

Please sign below to indicate that you agree to allow us to use this information in providing your services. You may choose to discontinue your participation in our online communications system at any time just simply notify us.

Print Name: _____

Signature: _____

Date: _____

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2023 Appointment Policy

CANCELLED or RE-SCHEDULED APPOINTMENT POLICY

We ask that you make every effort to give us at least a 72-hour notice if you cannot make your scheduled appointment.

If you are unable to give this notice, you will be charged **$50.00** for the missed appointment.

This includes same day cancelations or rescheduling your appointment.

When you give us 72-hour notice, your reserved time can be made available for another patient. When patients do not show for their appointment or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with another patient who has a true dental need. At this time, Lake Mary Family Dentistry will no longer able to waive any fees associated with cancelations or re-scheduled appointments.

Initial_____

LATE APPOINTMENT

Lake Mary Family Dentistry values our time with each patient. We ask that you please arrive on time to your scheduled appointment.

Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time.

Late arrivals more than 10 minutes will be re-appointed to another day.

Thank you for understanding the value of our cancellation policy to each of our patients.

Initial_____

I understand and agree to the 2023 Appointment Policy and understand I will be charged any applicable fees if accrued.

Signature (Patient) _____ Date _____

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