Lake Mary

Family Dentistry

New Patient Registration

Today's Date ________________

Last Name ________________________ First Name _______________________ MI _______ Date of Birth ____________________

Preferred Name: ________________________ Sex: M or F Social Security Number _______________________________________

Mailing Address: Street ____ City _______________ State____ Zip Code ____________

Email Address ________________________________ Home Phone (_____) _________________ Cell Phone (____) ______________

Employer _______________________ Work Phone (____) __________________ Occupation ________________________________

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Separated _____ Domestic Partner

Emergency Contact _______________________________ Relationship ______________________ Phone (_____) _______________

Person Responsible for Account ____ Relationship ________________________________

How did you hear about our office? □ In Home Mailer □ Insurance □ Facebook □ Other Social Media □ Google Search □ Practice Website

□ Referral: Who can we thank for you visit? _____________________________________ □ Other _______________________________

Are you a full time student? Yes or No If Patient is a minor: Mother's DOB ______________ Father's DOB ________________

Name of Parent ____ Parent Social Security Number _____________________________

Parent Employer __________________________________ Parent Phone (_____) ____

If you are completing this form on behalf of another person, what is your relationship to that person?

Name ____ Relationship ____

Dental Insurance Information

Insured Name ______________________________________

Insured's Employer ________________________________

Insurance Company _________________________________

Insurance Comp Address _____________________________

Insurance Comp Phone (____) ______________ DOB _______

Social Security Number ______________________________

Group Number ____________ Local Number _____________

Subscriber ID ______________________________________

Assignment and Release

I, the undersign, certify that I (or my dependent) have insurance coverage and assign directly to Lake Mary Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____

Relationship ____ Date _____________________________

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

Dental History and Background

Today's Date ________________

Last Name ________________________ First Name _______________________ MI _______

How may we help you today? ____

Are you experiencing any dental related pain at this time? ____

What is the most important thing to you about your dental visit today? ______________________________________

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

How frequently do you: floss / week ______ brush / day ______ Do your gums ever bleed after brushing or flossing? _____ Yes _____ No

Have you been diagnosed with (or undergone procedures involving) or do you have a general familiarity with any of the following?

Gum Infection	□ Diagnosed □ Familiar	**Crowns / Bridges**	□ Diagnosed □ Familiar	**Teeth Whitening**	□ Diagnosed □ Familiar
Periodontitis	□ Diagnosed □ Familiar	**Dentures**	□ Diagnosed □ Familiar	**Traditional Braces**	□ Diagnosed □ Familiar
"Deep Cleanings"	□ Diagnosed □ Familiar	**Partial Dentures**	□ Diagnosed □ Familiar	**Invisalign**	□ Diagnosed □ Familiar
Root Canals	□ Diagnosed □ Familiar	**Implants**	□ Diagnosed □ Familiar	**Night Guards**	□ Diagnosed □ Familiar

Have you been told by a physician that you require premedication (antibiotics) before dental treatment? _____ Yes ______ No

Have you ever had Bacterial Endocarditis? _____ Yes _____ No   Have you ever had a joint replacement? _____ Yes _____ No

Are you taking or have you ever taken any prescription or had any medical treatment for Osteopenia / Osteoporosis or Bone Disease? ____ Yes _____ No If so, please describe ____

Please share the following dates:

Your last cleaning _____ / _____ Your last oral cancer screening _____ / _____ Your last complete X-rays _____ / _____

Is there anything about your previous dental visits or experiences that would help the Lake Mary Family Dentistry team enhance your experience today? ____

Name of Previous Dentist ______________________________________ City ________________________ State _______

Reason for Leaving Previous Dentist ____

Here at Lake Mary Family Dentistry, we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services you'd like our team to discuss with you during your visit:

Invisalign	Dental Implants and Restorations	Teeth Whitening
Braces	Smile Makeover	Night Guard / Sport Guard
Complete Dentures	Root Canals	Partial Dentures
Crown and Bridge	Sealants	Porcelain Veneers / Lumineers
Bonding	Oral Surgery	Remove / Replace Teeth

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

________________________________ ________________________ ___________ ____________________

Signature of Patient / Legal Guardian   Print Name   Date   Dentist Signature

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Authorization to Release Information and Acknowledgement of Receipt of Notice of Privacy Practices

Last Name ________________________ First Name _______________________ MI ________

Designation for Release of Medical Information:
Dr. Pinney and the Lake Mary Family Dentistry team would like you to have the option to authorize a person (or persons) to whom the doctor and team can communicate with about your dental care, while maintaining your privacy and the information covered under the Privacy Act. If this is something you would like, please complete the following.

I, ____, authorize the following person (or persons) to have access to information covered under the Health Insurance Portability and Accountability Act regarding myself. I release Dr. Pinney and all staff members at Lake Mary Family Dentistry from any claim of confidentiality breach with the release of the information.

Name of Designated Person ______________________________________ Relationship ___________________________ Initial _____

Name of Designated Person ______________________________________ Relationship ___________________________ Initial _____

Name of Designated Person ______________________________________ Relationship ___________________________ Initial _____

____ _____________________________ ______________
Signature of Patient / Legal Guardian Print Name Date

If you would like to decline this option, please complete:

I, ____, decline to designate another person (or persons) to have access to information covered under the Health Insurance Portability and Accountability Act regarding myself and am aware that I can exercise this option in the future if I wish.

____ _____________________________ ______________
Signature of Patient / Legal Guardian Print Name Date

Acknowledgement of Receipt of Notice of Privacy Practices:

Note: You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of Lake Mary Family Dentistry's Notice of Privacy Practices.

____ _____________________________ ______________
Signature of Patient / Legal Guardian Print Name Date

-- FOR OFFICE USE ONLY --

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual Refused to Sign

□ Communication Barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please specify) ____

____

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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

Lake Mary
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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:

l 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: ____

l 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 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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Consent to Dental Photography

I, ________________________________, authorize

Dr. Grant Pinney and Lake Mary Family Dentistry to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following (please initial):

_____ Dental Records (This is required by the office as to allow records of treatment)

_____ Dental Education (Including Lectures, Seminars, Demonstrations, Professional Publications) (optional)

_____ Marketing Material (Including Websites and Printed Materials) (optional)

_____ Patient Education (optional)

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. If full face shot is used, further identification will be withheld.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Patient) ____

Date ________________

Lake Mary Family Dentistry

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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