Welcome to Lakeland Hills Dental Care

Grant S. Lo, DDS, PLLC

Patient Information

Date _____ **Sex: Male___ Female___ Age_____ Birth date** _____/_____/_____

Name _____ **Preferred Name**_____
(Last) (First) (Middle Initial) (If different than legal name)

Address_____ **Home Phone** _____

_____ **Cell Phone** _____

City _____**State** _____ **Zip** _____

Marital Status: Minor _____ **Single** _____ **Married** _____ **Other**_____

Email _____

Employer/Occupation_____ **Business Phone** _____

Emergency Contact: Name _____**Relation**_____ **Phone** _____

Whom may we thank for referring you?_____

Acknowledgement of Privacy Act

- I acknowledge receipt of the Notice of Privacy Practices and understand that Lakeland Hills Dental Care will use health information about me or my family members only in accordance to the Health Insurance Portability Accountability Act and the Notice of Privacy Practices for the offices of Grant S. Lo, DDS, PLLC.

Appointment and Financial Agreement

Canceling & Rescheduling Appointments

- An appointment is a commitment between the doctor and the patient. We have reserved that time just for you. If you are unable to keep your appointment, we require a 24-48 hour advance notice.
- **A Cancelled or Rescheduled appointment with less than 24 hours notice will be subject to a fee of $35 per appointment hour.**

Payment

- **Full payment is due at the time the services are rendered.**
- We accept Visa, MasterCard, American Express, Discover, Cash or Check.
- For patients without dental insurance, we offer a courtesy discount if payment is made in full at the time of service.

Insurance

- As a courtesy to our patients, we do file insurance claims on your behalf.
- **Full estimated co-insurance is due at the time of service.**
- I understand that insurance estimates are not always 100% accurate. Any amount that is not paid by my insurance company is my responsibility.
- I authorize my insurance company(s) to pay Lakeland Hills Dental Care all insurance benefits otherwise payable to me or my spouse for dental services rendered to me or members of my family.

I have read the policies described on this form and agree to abide by the terms outlined. I understand and accept my financial responsibilities.

Signature_____ Date_____

Lakeland Hills Dental Care

PATIENT NAME _____ **DATE** _____

Dental History

Reason for Today's Visit _____

Previous Dentist _____ Location_____ Phone_____

Date of last dental visit _____ Date of last dental X-rays _____

Are you dissatisfied with the appearance of your teeth? _____ Yes _____ No

If so why? _____

Indicate any of the following conditions. Place an "X" for all conditions that apply.

__ Bad Breath
__ Bleeding Gums
__ Clicking or Popping Jaw
__ Food Collection between Teeth
__ Grinding Teeth
__ Loose Teeth or Broken Fillings
__ Periodontal Treatment
__ Sensitivity to Cold
__ Sensitivity to Hot
__ Sensitivity to Sweets
__ Sensitivity to Biting
__ Sores or Growths in mouth

How often do you floss? _____ times per _____ How often do you brush? _____ times per _____

Medical History

Physician's Name _____ Location_____ Phone _____ Date of last visit _____

Have you had any serious illnesses or operations? ___ Yes ___ No If yes, describe _____

Have you ever had a blood transfusion? ___ Yes ___ No Please give approximate dates _____

Women: Pregnant? ___Yes ___ No Nursing? ___Yes ___ No Taking Birth Control Pills? ___Yes ___ No

Indicate any of the following conditions. Place an "X" for only those that apply.

__ Anemia
__ Arthritis, Rheumatism
__ Artificial Heart Valves
__ Artificial Joints
__ Asthma
__ Back Problems
__ Blood Disease
__ Cancer
__ Chemical Dependency
__ Circulatory Problems
__ Chemotherapy
__ Cortisone Treatments
__ Persistent Cough
__ Cough up Blood
__ Diabetes
Type I __
Type II __
Last AIC #: ____
__ Epilepsy
__ Fainting
__ Glaucoma
__ Headache
__ Heart Problems
__ Hemophilia
__ Hepatitis: Type ____
__ High Blood Pressure
__ HIV Positive/AIDS
__ Jaw Pain
__ Kidney Disease
__ Liver Disease
__ Mitral Valve Prolapse
__ Thyroid Problems
__ Neurological Problems
__ Pacemaker
__ Psychiatric Care
__ Radiation Treatment
__ Respiratory Disease
__ Shortness of Breath
__ Skin Rash
__ Stroke
__ Swelling of Feet or Ankles
__ Do you smoke or chew tobacco?
__ Tonsillitis
__ Tuberculosis
__ Ulcers
__ Venereal Disease

__ Other-Not Listed (Describe)_____

CURRENT MEDICATIONS (please also include supplements)

_____
_____
_____

ALLERGIES, DRUG ALLERGIES

_____
_____
_____

Verification

I verify that the medical history information provided above to be complete and accurate. I understand that I am responsible for any errors of omissions as well as updating the dentist on any future changes in my medical history.

SIGNATURE _____ **DATE** _____