Lisa Martin, DDS
7401 West Ranch Road 2147 / P.O. Box 4208
Horseshoe Bay, TX 78657
Phone: 830-693-3684 Fax: 830-549-2134
Call: 1-830-MY-DENTIST
Email: lakecountrydental@gmail.com
Website: lakecountrydentalhsb.com

Patient Information

Date: _____

Patient Name: _____ Preferred Name: _____ *Dental Insurance: YES / NO*

Gender: Male Female Marital Status: Married Single Minor Other

Date of Birth: _____ Age: _____ SS#:_____DL#:_____State_____

Employer: _____ Occupation: _____

Home Phone: _____ Work: _____ Ext: _____ Mobile: _____

Mailing Address: _____

Physician's Name & Phone #:_____Date of last visit: _____

Name of Previous Dentist: _____Date of last visit: _____Date of last X-Rays: _____

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

Emergency Contact's Name & Phone #:_____

Email Address: _____

Responsible Party Information

☐*Same as Patient Information*

Name: _____ Relation to Patient: _____

Date of Birth: _____ Age: _____ SS#:_____DL#:_____State: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work: _____ Ext: _____ Mobile: _____

Mailing Address: _____

Primary Insurance Information

Subscriber's Name: _____ Date of Birth: _____ SS#:_____

Subscriber's Employer: _____Subscriber's Occupation: _____

Subscriber's Phone #:_____ Subscriber's Work #:_____

Subscriber's relation to Patient: _____

Dental Insurance: _____Insurance Phone #:_____

Group #:_____ Member ID#:_____

Mailing Address: _____

Information for our Patients with Dental Insurance

As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance and gladly file your insurance claims.

- ***Payment Policy***: Our office is a fee for service office, meaning we politely ask for your portion of payment in full at the time services are rendered. For your convenience, we accept:
  - Cash or Check
  - Care Credit payment plans
  - Visa, Mastercard, Discover Card, American Express
- Occasionally ***you may receive a payment from your insurance company*** that should have been sent to us directly. If so, you will be responsible to ***forward*** that ***check*** and a copy of the EOB to our office ***within five days of receipt***.
- We ask that you understand that the ***policy belongs to you*** and we have no leverage to obtain payment from your insurance. With that, we ask that you ***take responsibility for payment of your visit should your insurance company not pay within 65 days of your appointment date***. In order to avoid this situation, we ask that you ***keep our office informed of any changes in your insurance coverage or employment.***
- Every dental insurance policy has a maximum benefit, which we are able to track for services rendered in our office. If you have received care by another office, we cannot be responsible for calculating your remaining benefits accurately. You may call your insurance company to receive an updated amount remaining after services have been paid to all office(s) involved.
- ***On the date of your office visit, you are responsible for the portion we estimate the insurance will not cover. However, if our estimates are inaccurate, there will be a need to send you a billing statement for the balance due. We ask that you remit payment upon receipt of this statement.***

FOR YOUR INFORMATION…..

- Dental insurance pays based on the premium paid. Higher premium plans pay more of the fees for your dental care. Dental insurance is to help in defraying costs of dental care and typically requires a patient copayment for most dental services.
- Dental insurance policies reduce payment for some services, use restricted fee schedules and exclude some procedures based on prior conditions and/or waiting periods. Every plan is written differently based on the request(s) of your employer.
- ***The type of treatment you need and receive from our office is based upon the Dentist's professional judgment, and not on the coverage you receive from a dental benefit plan. We do not believe it is in YOUR best interest for us to compromise your recommended treatment in order to accommodate an insurance program.***
- It is very important to understand that dental plans are not in business to make sure you receive the care you need – their only responsibility is to pay for the services your employer has purchased.

If benefits are assigned, I hereby authorize benefits to be paid directly to Lake Country Dental. I understand that the recommended treatment has been diagnosed as standard practice, and agree to the financial liability regardless of the necessity determined by my insurance carrier. If services are excludable from coverage, I have been made aware of their fee in the treatment plan presented. I further understand that I am responsible for understanding the benefits and limitations of my dental plan coverage.

_____

Patient Signature or Responsible Party Date

Office Policy

Financial Policy

An important part of our mission is making the cost manageable for our patients. Payment is due at the time services are rendered. If your insurance plan requires a copayment, payment of the co-payment is required at the time services are provided.

You can choose from:

- Cash or Check
- Visa, Master card, American Express or Discover Credit Cards
- Care Credit – 6 to 12 months interest free available

Dental Insurance Policy

We will gladly work with you to maximize your insurance benefits. Realize that dental insurance policies restrict payment for some services, use negotiated fee schedules and exclude some procedures based on prior conditions and/or waiting periods. Understanding your insurance benefits can be very challenging, and each plan differs. If you have any specific questions regarding your policy, you should contact your employer or insurance carrier directly. We will file your dental insurance claims and request payment of your benefit directly to our office.

Returned Check / Collection Policy

We do charge a $35.00 fee for a nonsufficient/returned check from your bank and a $25.00 collection fee for accounts sent to our outside collection agency. We do send 90 day past due accounts to an outside collection agency.

Failed Appointment Policy

We reserve our time, facilities and equipment especially for you to receive high quality dental care. To keep our fees from rising, we politely request at least ***24 hour notice*** if you are unable to keep a reserved appointment. ***Without this notice, we reserve the right to charge a $30.00 broken appointment fee. After two failed or broken appointments per family we ask that you prepay a deposit of $50.00 at least 24 hours prior to your next appointment.*** This will go toward your dental treatment on your reserved appointment day or if you are unable to make the appointment it will go to the office. We ask that you please try to understand our position on this delicate situation and kindly confirm your reserved appointment with our office no later than 24 hours before your appointment time.

Fee Estimates

I understand that the fee estimates for dental care can only be extended for a period 6 months from the date of consultation.

Late Arrivals

We attempt to schedule our patients as efficiently as possible to reduce your wait time in our reception area. Due to this method of scheduling, it is imperative that we are able to start your appointment at the time we have scheduled for you. If you arrive for your appointment more than 15 minutes late, we do reserve the right to reschedule your appointment for another day and time. As always, we try our very best to honor your appointment time to the best of our abilities. With this policy in mind, if our office runs behind for your appointment more than 15 minutes, we will allow you to reschedule your appointment.

With these policies in place, we are able to provide you with outstanding dental treatment at a fair price. If you have any questions, at any time, please do not hesitate to discuss these with us. We are here to help you achieve the quality care you deserve. Thank you.

I assign all dental benefits, if any, directly to Lake Country Dental. I understand that my dental insurance carrier may pay less than the estimated or actual bill of services. I understand and acknowledge that I am financially responsible for payments in full on all accounts for services provided for myself and/or any dependents, regardless of my Dental Insurance Benefits.

_____

Patient Signature or Responsible Party Date

Lake Country Dental Mission Statement

Thank you for choosing Lake Country Dental, where we treat patients how we would like to be treated with compassion and integrity. Our primary mission is to strive for, attain and provide you with long lasting high quality dental care. We also realize that every patient has different wants and desires and we are here to assist you in making the best educated decisions for your oral health. We strive to establish a long lasting relationship with each and every patient driven by trust, comfort and friendship. By trying to understand and relate to our patients as individuals, we can provide the exceptional care they deserve. We pledge to provide the finest personal service in a warm, relaxed and caring environment.

Acknowledgement of Privacy Rights

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the ***Health Insurance Portability & Accountability Act*** of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my (or my dependents) treatment among a number of health care providers who may be involved in that treatment directly and indirectly by phone, fax, mail, or email
- Obtain payment from third-party payers for my health care services by phone, fax, mail or email
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. Dependent family members also covered by this acknowledgement.

Patient Name: _____ Date: _____

Signature: _____ Lake Country Dental

Relationship to Patient: _____ Lisa Martin, DDS

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

Communications barriers prohibited obtaining the acknowledgement _____ Individual refused to sign _____

An emergency situation prevented us from obtaining acknowledgment _____ Other (Please Specify): _____

Dental Information

1. **Reason** for today's visit: _____ Are you in **pain**? YES / NO

Please circle any of the following problems that apply:

Discomfort, clicking or popping in jaw	Lost/Broken Filling(s)	Stained Teeth
Red, swollen or bleeding gums	Grinding/Clenching	Locking Jaw
Sensitive tooth, teeth or gums	Ringing/Pain in Ears	Bad breath
Blisters/Sores in or around the mouth	Broken/Chipped tooth	Dry Mouth
Burning Sensation on Tongue	Lip or Cheek Biting	Mouth Breathing
Chew on one side of mouth	Fingernail Biting	Orthodontic Treatment
Food collection between teeth	Periodontal Treatment	Sensitivity to Cold, Hot, Sweets
Gag Easily	Difficulty Chewing	Other: _____

Briefly tell us how you feel about your teeth, your smile and dental expectations.

2. What are your expectations from this office? _____

   _____

3. Have your past dental office experiences been **positive**? _____

   If no, please explain: _____

4. Is there anything in particular you would always ***like*** us to do for you or would like us ***never*** to do? Explain: _____

5. Do you have any dental **concerns** not listed here that you would like to bring to our attention?

   Explain: _____

6. Are you **apprehensive** about dental treatment? Never Sometimes Always

7. Have you had **problems** with ***previous dental treatment***? YES / NO

   Explain: _____

8. Have you ever had **nitrous oxide** (laughing gas), **general anesthesia** or **oral sedation** during dental treatment? YES / NO

9. How many times a day do you **brush**? _____ Times of week you **floss**?_____

10. What **type** of tooth brush bristles do you use? Soft Medium Hard

11. How would you ***rate your smile***? (*worst*) 1 2 3 4 5 6 7 8 9 10 (*best*)

12. Would you **change** anything about it? _____

13. Are you interested in **whitening**? YES / NO

Medical Information

1. ***Circle*** any of the following you have ***EVER*** had or ***HAVE*** at present: YES / NO

Acid Reflux /GERD
AIDS/HIV
Alcohol / Drug Abuse
Allergies
Anemia
Ankles / Legs Swelling
Anticoagulant Therapy
Arthritis / Rheumatism
Artificial Heart Shunts
Artificial Joints
Asthma
Back Pain / Neck Pain
Bleeding Problems
Blood Disease
Blood Transfusion
Cancer
Chemotherapy
Chest Pain
Congenital Heart Disease
COPD
Cortisone Treatments
Depression
Diabetes
Difficulty Breathing
Easy Bruising
Eating Disorder
Emphysema / Bronchitis
Epilepsy
Fainting / Dizziness
Fibromyalgia
Glaucoma
Headaches
Head Injuries
Heart Attack
Heart Bypass Surgery
Heart Disease / Problems
Heart Murmur
Heart Stent Placement
Heart Transplant
Heart Valve Placement
Hemophilia
Hepatitis Type _____
Herpes
High / Low Blood Pressure
Hormone Medication
Immune System Deficiency
Infective Endocarditis
Jaundice
Jaw Problems, TMJ / TMD
Kidney Disease / Problems
Leukemia
Liver Disease / Problems
Lupus
Mental / Nervous Disorder
Mitral Valve Prolapse
Nutritional Deficiencies
Organ Transplant
Osteoporosis
Pacemaker
Panic Attacks / Anxiety
Persistent Cough
Pregnancy
Psychiatric Therapy
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Sleep Apnea / Snoring
Stomach Problems
Stroke / TIA
Swollen glands
Thyroid Problems
Tobacco Use
Tuberculosis
Tumors
Ulcers
Venereal Disease

2. List **ANY** surgeries, diseases or medical conditions not listed:_____

_____

3. Have you ever had any **ALLERGIC** or **ADVERSE REACTION** to any of the following? YES / NO

Aspirin
Barbiturates
Clindamycin
Codeine
Erythromycin
General Anesthesia
Halcion / Triazolam
Hydroxyzine
Ibuprofen
Latex
Local Anesthetics
Nitrous Oxide
Penicillin / Amoxicillin
Sedatives
Sulfa Drugs
Tetracycline
Tylenol
Valium
Vicodin / Hydrocodone
Other: _____

Medical Information Continued

4. **Ladies:** are you **PREGNANT**? *YES* / NO Due:_____ Nursing Taking Birth Control

5. Have you **EVER** been told by a Doctor that you require **PRE-MEDICATION** with antibiotics prior to Dental Care for a **HEART CONDITION** or **JOINT REPLACEMENT**, **ETC**.? Yes No Not Sure

6. Are you taking any **ANTICOAGULANTS**? (Plavix, Coumadin, Warfarin, Aspirin)? Yes No Other

7. Have you ever had a **BLEEDING** problem? YES / NO

   If yes please explain:_____

8. Are you taking or have you **EVER** takin oral or IV **BISPHOSPHONATES FOR OSTEOPOROSIS**? YES / NO

Actonel / Risendronate	Skelid / Tiludronate	Atelvia / Risedronate
Alendronate / Fosamax	Reclast / Zoledronic acid	Aclasta / Zoldronic acid
Boniva / Ibandronate	Zometa / Zoledronic acid	
Etidronate / Didronel	Fosamax Plus D /	
Pamidronate / Aredia	Alendronate with Vitamin D	

9. Are you presently under the care of a **Physician**? Yes / No If yes, for what reason and date of last office appointment:_____

10. Please list any ***DRUGS*** or ***MEDICATIONS*** you are presently taking:_____

_____

_____

_____

11. Please add **anything** about your medical or dental history you feel is important for us to know:

_____

I have read and answered all the Medical and Dental questions to the best of my knowledge. I understand that if there are any changes to my health history I will inform the doctor and staff at my next appointment without fail. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

_____

Patient Signature or Responsible Party Date