Lisa Martin, DDS
9712 FM 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 / Widowed / Divorced / 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: _____

Previous Dentist Name & Phone #: _____Date of last Cleaning & X-Rays: _____

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

Email Address: _____

Emergency Contact's Name & Phone #: _____

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

We Are Out Of Network with all Dental Plans

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#:_____

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. **We are out of network with all insurance companies.**

- ***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
  - ○ Cash or Check
  - ○ Sunbit payment plans
  - ○ 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 from 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
- Sunbit – different terms 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 non-sufficient/returned check from your bank and a $50.00 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 your dental care. 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 $50.00 broken appointment fee. After two failed or broken appointments per family we ask that you prepay for your next appointment.*** 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

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of *unsecured protected* health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information *for* public health activities, including disclosures to:
• Prevent or control disease, injury or disability;
• Report child abuse or neglect;
• Report reactions to medications or problems with products or devices;
• Notify a person of a recall, repair, or replacement of products or devices;
• Notify a person who may have been exposed to a disease or condition; or notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI. Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written

authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you *a* reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.
If you are *denied a* request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (**2)** whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances**.** If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient Signature or Responsible Party Date

Dental Information

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

Please circle any of the following problems that apply:

Jaw / TMD Problems	Broken/Chipped teeth/filling(s)	Stained Teeth
Red, swollen or bleeding gums	Grinding/Clenching	Sensitive tooth, teeth or gums
Bad breath / Dry Mouth	Mouth Breathing	Blisters/Sores in/around mouth
Food collection between teeth	Sensitivity to Cold, Hot, Sweets	Loose, Tipped, Shifting teeth
Gag Easily	Pain or 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? Is there anything you would always like or never like us to do? Explain:_____

3. Why did you leave your previous dentist? Explain: _____

4. Do you have any dental **concerns** not listed here that you would like to bring to our attention? Explain: _____

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

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

Explain: _____

7. Have you had **nitrous oxide**, **general anesthesia** or **oral sedation** during dental treatment? YES / NO

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

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

10. Do you have or have you had any of the following:

Dentures	Partial Dentures	Braces	Crowns
Bridges	Periodontal (gum) treatments	Veneers	Implants

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

Whiter/Brighter Teeth	Straighter Teeth	Close Spaces
Repair Chipped Teeth	Replace Missing Teeth	Smile Makeover

Replace Metal Fillings with tooth-colored fillings Replace Old Crowns that do not Match

Medical Information

1. ***Circle*** any of the following medical conditions you currently **HAVE** or have ***EVER*** had:

Acid Reflux /GERD
AIDS/HIV
Alcohol / Drug Abuse
Allergies / Sinus Problems
Anemia
Anticoagulant Therapy
Arthritis / Rheumatism
Artificial Joints
Asthma / Respiratory Disease
Back / Neck Pain
Bleeding Problems / Bruising
Blood Disease/Blood Transfusion
Cancer
Chemo / Radiation Therapy
Chest Pain
Congenital Heart Disease
COPD/Sleep Apnea/Snoring
Cortisone Treatments
Depression
Diabetes
Difficulty Breathing
Eating Disorder
Emphysema / Bronchitis
Fainting / Dizziness
Fibromyalgia / Lupus
Glaucoma
Headaches / Earaches
Head Injuries
Heart Attack / Bypass Surgery
Heart Murmur
Heart Valve, Stent Placement Heart Transplant
Hepatitis Type A / B /C
Herpes / HPV
High / Low Blood Pressure
Hormone Medication
Immune System Deficiency
Infective Endocarditis
Kidney Disease / Problems
Leukemia
Liver Disease / Problems
Mitral Valve Prolapse
Nutritional Deficiencies
Organ Transplant
Osteoporosis
Pacemaker
Panic Attacks / Anxiety
Pregnancy
Psychiatric Therapy
Rheumatic / Scarlet Fever
Seizures
Stroke / TIA
Swollen glands
Thyroid Problems
Tobacco Use
Tumors / Ulcer

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
Clindamycin / Erythromycin
Azithromycin / Z-Pak
Codeine
General Anesthesia
Halcion / Triazolam
Hydroxyzine
Ibuprofen
Latex
Local Anesthetics / Nitrous Oxide
Penicillin / Amoxicillin
Sulfa Drugs / Bactrim
Tetracycline / Doxycycline
Tylenol
Valium
Vicodin / Hydrocodone
Steroids
Other: _____

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

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

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

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

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

8. Have you ever had a **BLEEDING** problem? YES / NO Explain: _____

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

Photography Release

I ***(Do / Do Not)*** authorize and consent to the use of photographs / x-rays of me taken by Lake Country Dental at the address of 9712 F.M 2147 Unit 105 in Horseshoe Bay Texas 78657. I grant them permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance.

I do consent to the use of my photographs or images for marketing materials including website and patient education for Lake Country Dental only. I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used.

No full face or comparable photos will be used without your express written authorization.

I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

Patient's Signature: _____ Date: _____

Dentist Signature: _____ Date: _____