Lifetime Dental
family, cosmetic and implant dentistry

New Patient Registration

Today's Date:_____ Whom May We Thank For Referring You?_____

Patient Name:_____ Date Of Birth:_____ Age:_____

Preferred Name:_____ Sex: M F Social Security Number:_____

Street Address:_____City:_____ State:_____

Zip Code:_____ Home Phone:_____ Work:_____ Cell:_____

Email Address:_____ Occupation/School:_____

Employer Name:_____Address:_____

Person To Contact In Case Of Emergency:_____Phone:_____

Spouse's Name:_____ Phone:_____ Work:_____

Primary Insurance Information

Name Of Policy Holder:_____ Relationship to Patient:_____

Social Security Number:_____ Insured Date Of Birth:_____

Insured Employer Name:_____

Insurance Name:_____ Insurance Phone Number:_____

Member ID:_____ Group Number:_____

Responsible Party Information

Name Of Person Responsible For Account:_____ Date Of Birth:_____

Social Security Number:_____ Address:_____

Phone:_____ Work:_____ Cell:_____ Email:_____

Relationship To Patient:_____

Privacy Disclosure

Persons To Discuss Treatment/Finances With _____ _____

I have had the opportunity to read and obtain a copy of Lifetime Dental's Privacy Practices and I give my consent to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

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Medical Information

The following information about your health history is very important to us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. ALL questions must be answered completely and accurately. If you do not understand, are unsure of an answer, or would like to discuss an item with Dr. Her, please let us know. This questionnaire will become part of your dental treatment record and will be kept confidential.

Patient Name:_____ Today's Date:_____

Dental History

What are your dental concerns?_____ Date of last dental visit/cleaning?_____

What would you like to change about your smile?_____

Do you floss and brush daily? Yes No Do your gums bleed while brushing/eating? Yes No

Are your teeth Sensitive to hot/cold or pressure? Yes No Clicking in Jaw/Joints? Yes No

Any injury to teeth, jaw or face? Yes No Any complications during previous dental treatment? Yes No

Medical History

Women: Are you pregnant? Yes No If Yes, how many months?_____ If no are you on birth control pills? Yes No

Have you been hospitalized or under the care of a physician during the past two years? Yes No If yes, how long ago and reason for treatment:_____

Physician Name:_____ Phone:_____

Current Medications/Conditions they treat:_____

_____

Do you have any drug allergies? Yes No If yes, which medication:_____

Do you have or have you had any of the following? Please Circle

Heart Disease	Bruise Easily	Hay Fever or Sinus	Skin Condition
Angina Pectoria	Stroke	Thyroid Disease	Latex Allergy
High Blood Pressure	Epilepsy or Seizures	Diabetes	Mitral Valve Prolapse
Heart Murmur	Fainting or Dizzy Spells	Neurological Disorder	Headaches/Sinus Problem
Rheumatic Fever	Radiation Treatment	Arthritis/Rheumatism	Ankle Swelling
Congenital Heart Condition	Chemotherapy	Glaucoma	Other:_____
Heart Surgery/Pacemaker	Cancer	Fever Blisters/Cold Sores	
Artificial Joint/Heart Valve	Kidney Trouble	Venereal Disease	
Anemia	Ulcer/Stomach Disorder	Hepatitis	
HIV Positive	Emphysema	Liver Disease	
Leukemia	Tuberculosis	Jaundice	
Hemophillia	Asthma or Bronchitis	Drug or Alcohol Addiction	

Commitment Letter

Our Commitment

At Lifetime Dental, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as well with all relationships, need open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

As a courtesy to you, we will submit insurance claims on your behalf. We will provide all necessary documentation that your insurance requests to settle your claim in a timely manner.

We understand how valuable your time is, so we make every effort to remain on time. We feel that you deserve our complete and focused attention so that we may provide the best possible care. Your reserved time is exclusively yours.

Your Commitment

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Your co-payment for treatment is expected at the time of service. Cosmetic or large treatment case payments are due at time of reserving the appointment. For your convenience we do accept many forms of payment including cash, check, Visa, Mastercard, Discover, American Express and we also offer third party financing which includes both interest free and extended financing programs.

Insurance is a contract between you and your insurance carrier. All co-payments collected or discussed are estimates. Any claim that is denied or not paid according to the estimate we provide is ultimately your responsibility. If insurance has not made payment within 30 days of billing, all balances will become your responsibility.

Your appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We do understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 48 hour notice is given. If sufficient notice is not given, your account will be charged $75.00 for the missed appointment. We ask that you make every effort to confirm your reservation and also keep your reserved time.

Patient Signature:_____ Date:_____

Administrative Signature:_____ Date:_____