PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ________________________________ Preferred name __________________ Birth date___________

Cell phone-____________Home phone _____________Work phone _____________If minor, parent names _________________

Mailing address ____ City ____________________State ________ Zip ___________

Employer ____________________________________ Spouse's Name__________________ Spouses DOB_________________

Email Address _________________________________ ❑ Male ❑Female Best way to confirm appointments _______________

Whom may we thank for referring you to our office? ____

Emergency Contact________________________Phone number: _________________Relationship-_____________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____________________ Dental Insurance Co._________________ Group number____________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company ______________________ Group number __________________

Spouse's birthday ______________________ Social Security number ___________________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

Condition		
Cancer or tumor	❑ yes	❑ no
Heart Disease	❑ yes	❑ no
Heart murmur/defect	❑ yes	❑ no
Mitral valve prolapse	❑ yes	❑ no
Rheumatic fever/disease	❑ yes	❑ no
Artificial joint or valve	❑ yes	❑ no
High/low blood pressure	❑ yes	❑ no
Pacemaker	❑ yes	❑ no
Tuberculosis	❑ yes	❑ no
Kidney disease	❑ yes	❑ no
Hepatitis/liver disease	❑ yes	❑ no
Alcoholism	❑ yes	❑ no
Addiction	❑ yes	❑ no
Blood transfusion	❑ yes	❑ no
Diabetes Type ____	❑ yes	❑ no
Neurologic condition	❑ yes	❑ no
Epilepsy/Seizures	❑ yes	❑ no
Fainting spells	❑ yes	❑ no
Emotional condition	❑ yes	❑ no
Arthritis	❑ yes	❑ no
Herpes or cold sores	❑ yes	❑ no
AIDS or HIV positive	❑ yes	❑ no
Migraine headaches	❑ yes	❑ no
Frequent headaches	❑ yes	❑ no
Anemia/blood disorders	❑ yes	❑ no
Abnormal bleeding	❑ yes	❑ no
Hayfever or sinus trouble	❑ yes	❑ no
Allergies or hives	❑ yes	❑ no
Asthma	❑ yes	❑ no
Sleep apnea/Suspected	❑ yes	❑ no
Tobacco use	❑ yes	❑ no How much ______

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_______________________________________

Are you taking any of the following? (attach list if needed)

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Vitamins
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Bisphosphonates- Oral or IV
- ❑ Other____

____
____
____
____
____

Women:

- ❑ May be pregnant
  Expected delivery date: _____________
- ❑ Taking hormones or contraceptives

Name of your physician:___________________Ph#__________________Previous Dentist _________________________________

Do you have any disease, condition, or problem not listed above?____

Signature of patient (or parent) _______________________________________ Date _________________

Lilac Family Dental
214 West Commercial Street
East Rochester, NY 14445
(585)586-4674

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how the practice may use and disclose my confidential information. **I am only acknowledging receipt of the policy**. Please specify your relationship to the patient **:** ________________________________

______________________________________ ______________________________

Signature of patient or representative Date

SSN#________________________________

INFORMATION AUTHORIZATION

For Lilac Family Dental to disclose private health information about
you to parties not covered in our Notice of Privacy Practices, you will need to complete this section.

☐ Yes, you may provide information to the parties listed below:

____

____

☐ No, I do not wish Lilac Family Dental to discuss my information
with any party other than myself.

______________________________________ ______________________________

Signature of patient or representative Date

Office Financial Policy
Lilac Family Dental
214 West Commercial Street
East Rochester, NY 14445
585-586-4674

Our financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying their dental care.

1.) Full payment or copay is expected at the time of service unless other arrangements have been made prior to your appointment.

2.) A rebilling charge of $10.00 per month on the unpaid balance will be charged after 30 days.

3.) If there are repeated broken appointments or canceled appointments with less than 24 hours notice there may be a $25.00 charge applied to your account.

4.) Returned checks are subjected to a $25.00 service charge and will terminate your privilege to pay by check in the future. Only Cash, Visa, Master Card, Discover or Care Credit will be accepted.

5.) It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, you will be fully responsible for all collection agency fees and attorney fees.

Please sign and date below to indicate that you have read and fully understood said policy.

Patient Name: ____

Signature: ______________________Date: ______________________

Assignment and Release

I certify that I, and/or my dependent(s) , have insurance coverage with ___________________ and assign benefits directly to **Lilac Family Dental** 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 authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature:_____________________ Date:_______________________

Lilac family dental
Making Healthy Smiles Bloom

Sleep Evaluation

Name: ___________________________

Please complete the following:

Height__________ Age__________

Weight __________ M/F __________

Do you currently use a C-pap machine? ___________

1. Do you snore?
   - o Yes
   - o No
   - o Don't know

If you snore:

2. Your snoring is?
   - o Slightly louder than breathing
   - o As loud as talking
   - o Louder than talking
   - o Very loud. Can be heard in adjacent rooms.

3. How often do you snore?
   - o Nearly every day
   - o 3-4 times a week
   - o 1-2 times a week
   - o 1-2 times a month
   - o Never or nearly never

4. Has your snoring ever bothered other people?
   - o Yes
   - o No

5. Has anyone noticed that you quit breathing during your sleep?
   - o Nearly every day
   - o 3-4 times a week
   - o 1-2 times a week
   - o 1-2 times a month
   - o Never or nearly never

6. How often do you feel tired or fatigued after you sleep?
   - o Nearly every day
   - o 3-4 times a week
   - o 1-2 times a week
   - o 1-2 times a month
   - o Never or nearly never

7. While awake, do you feel tired, fatigued or not wake up to par?
   - o Nearly every day
   - o 3-4 times a week
   - o 1-2 times a week
   - o 1-2 times a month
   - o Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - o Yes
   - o No

If yes, how often does this occur?

- o Nearly every day
- o 3-4 times a week
- o 1-2 times a week
- o 1-2 times a month
- o Never or nearly never

9. Do you have high blood pressure?
   - o Yes
   - o No

Sleep Evaluation **Name:** ___________________________