Lancaster Smiles
family & cosmetic dentistry, P.C.
Michael E. Funk, DMD

# NEW PATIENT INFORMATION

We are committed to providing you with the best service possible. In order to help us serve you better, we appreciate you taking the time to complete this confidential questionnaire. If you have any questions or need assistance, please don't hesitate to ask us - we will be happy to help.
Whom may we thank for referring you or how did you hear about us?_____

## ABOUT YOU

[ ] Male [ ] Female

Name: _____ I prefer to be called: _____

[ ] Single [ ] Married [ ] Child [ ] Other

Birth Date: ___/___/_____ Age: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (  ) _____ Mobile/Cell Phone: (  ) _____ Email Address: _____

Employer: _____ Years At Current Employer _____ Occupation: _____

Work Phone: (  ) _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Preferred Method To Contact You: [ ] Home Phone [ ] Cell Phone [ ] Email

## PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above (if yes, you can skip this section)

Name: _____ Birth Date: ___/___/_____ Relation: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Phone: (  ) _____ Work: (  ) _____ Social Security #: _____

## DENTAL INSURANCE INFORMATION

**Primary Insurance**

Insurance Co. Name: _____ Phone: (  ) _____ Group/Policy #: _____

Insured's Name: _____ Birth Date: ___/___/_____ Relation: _____

Insured's ID #: _____ Insured's Employer: _____

**Secondary Insurance**

Insurance Co. Name: _____ Phone: (  ) _____ Group/Policy #: _____

Insured's Name: _____ Birth Date: ___/___/_____ Relation: _____

Insured's ID #: _____ Insured's Employer: _____

## EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Phone: (  ) _____ Work: (  ) _____

# MEDICAL HISTORY INFORMATION

Name Of Physician: _____ Phone: (  ) _____

Do you have or have you ever had any of the following?
Please check those that apply:

| | | | |
|---|---|---|---|
| [ ] Allergies/Hay Fever | [ ] Diabetes | [ ] Heart Surgery* | [ ] Rheumatic Fever |
| [ ] Anemia | [ ] Epilepsy or Seizures | [ ] Hepatitis | [ ] Rheumatism |
| [ ] Angina | [ ] Excessive Thirst | [ ] High Blood Pressure | [ ] Sickle Cell Disease |
| [ ] Arthritis | [ ] Fainting or Dizziness | [ ] HIV*/AIDS | [ ] Sinus Problems |
| [ ] Artificial Joints* | [ ] Fever Blisters/Cold Sores | [ ] Kidney Problems | [ ] Stroke |
| [ ] Artificial Heart Valves* | [ ] Frequent Cough | [ ] Liver Problems | [ ] Surgical Shunt* |
| [ ] Asthma | [ ] Glaucoma | [ ] Mental Disorders | [ ] Thyroid Problems |
| [ ] Breathing Problems | [ ] Heart Disorder (Congenital)* | [ ] Mitral Valve Prolapse* | [ ] Tuberculosis |
| [ ] Cancer | [ ] Heart Infection* | [ ] Osteoporosis | [ ] Ulcers |
| [ ] Chemical Dependency | [ ] Heart Murmur* | [ ] Radiation Treatment | [ ] Venereal Disease |
| [ ] Chemotherapy | [ ] Heart Pace Maker* | [ ] Respiratory Problems | [ ] Yellow Jaundice |

*This condition may require antibiotic premedication for certain dental procedures.

**Yes** **No**

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes, please explain: _____

[ ] [ ] Are you now under the care of a physician?
If yes, please explain: _____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: _____

[ ] [ ] Are you taking any medications or herbals?
If yes, please list: _____

[ ] [ ] Are you allergic to any medications or substances? Please check appropriate boxes below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Metal [ ] Latex [ ] Sulfa [ ] Other: _____

[ ] [ ] Have you used tobacco? How many years? _____
[ ] Cigarettes [ ] Chewing Tobacco [ ] Cigars [ ] Pipe

WOMEN (Please check any that apply)
[ ] Pregnant [ ] Nursing [ ] Birth Control

To the best of my knowledge, all of the preceding information is correct. If I have any changes in my health status or medications, I will inform the dentist and staff at the next appointment without fail.

X_____ Date: ___/___/_____

# DENTAL HISTORY INFORMATION

How may we help you today? _____

Your current dental health is: [ ] Good [ ] Fair [ ] Poor

| Yes | No | |
|---|---|---|
| [ ] | [ ] | Do you require antibiotics before dental treatment? |
| [ ] | [ ] | Are you currently in pain? |
| [ ] | [ ] | Have you ever had gum treatment? |
| [ ] | [ ] | Do you now or have you ever had any pain/discomfort in your jaw joint (TMJ)? |
| [ ] | [ ] | Are you under stress (new job, moving, relationships)? |
| [ ] | [ ] | Do you like your smile? |
| [ ] | [ ] | Is there anything you would like to change about your smile? |
| [ ] | [ ] | Are you happy with your teeth? |
| [ ] | [ ] | Do your gums bleed? |
| | | How many times do you: floss per week? _____ brush per day? _____ |
| [ ] | [ ] | Are your teeth sensitive to heat, cold or anything else? |
| [ ] | [ ] | Have you lost any teeth? |
| [ ] | [ ] | Have you ever had a serious/difficult problem with any previous dental work? |
| [ ] | [ ] | Have you ever had any unfavorable dental experiences? |
| | | When was your last dental cleaning? _____ |
| | | When was your last dental visit? _____ |
| | | Why did you leave your previous dentist? _____ |
| | | How can we accommodate you better during your dental visits?_____ |

At Lancaster Smiles we offer a variety of services to help enhance and keep your smile beautiful.
Please circle any services below that you would like our friendly staff to discuss with you during your visit:

| | | |
|---|---|---|
| Tooth Whitening | Cosmetic Tooth Colored Fillings | Veneers |
| Smile Makeover | Bonding | Sealants |
| Crown and Bridge | Implant Crowns | Partials/Dentures |
| Night/Sport Guards | Root Canals | |

# DENTAL HEALTH QUESTIONNAIRE

Every patient should have the opportunity to know what their current level of dental health is, how they got there and what options they have for treatment. Our goal is to provide a personalized treatment plan for you. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissue. We will take x-rays and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate any areas of concern.

Once we have taken diagnostic tests, they will be carefully evaluated to determine your level of dental health. With careful review, we will share our findings with you and discuss your treatment options - then we can make a personalized treatment plan to help you achieve your dental health goals.

Please help us better understand your dental health needs and goals by answering the following questions:

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years?
   [ ] **Yes** [ ] **No**
2. I have a [ ] **low** [ ] **moderate** [ ] **high** level of fear of going to the dentist.
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not** comfortable.
4. I am [ ] very satisfied [ ] satisfied [ ] dissatisfied with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor**.
6. I would say that my main concerns with my dental health are: _____
7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. [ ] **Yes** [ ] **No**
8. Please check which statement below best represents the level of dental health you wish to achieve.
   (Some people begin at one level and progress to a higher level over time.)

[ ] **Health Level I - Emergency Care**

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment.
I am not interested in any additional care at this time.

[ ] **Health Level II - Maintenance Care**

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

[ ] **Health Level III - Comprehensive Care**

I am interested in comprehensive care to achieve and maintain a higher level of dental health.
I am concerned about treating the causes of dental diseases, not simply the effects.
I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

[ ] **Health Level IV - Comprehensive & Cosmetic Care**

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.
I am concerned about treating the causes of dental diseases, not simply the effects.
I want all dental treatment provided to be the best available in standard and cosmetic dentistry for maximum protection, longevity and aesthetics so I can achieve long-term stable, yet aesthetic dental health.

## APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our waiting area as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. In the event you must change your appointment, please provide us at least **2 business days of advanced notice** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours. **A fee of $50 may be charged for appointments broken, changed or rescheduled with less than 36 hours notice.**

## FINANCIAL POLICY

Unless another financial option is pre-arranged, payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Lancaster Smiles, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

**Payment Options**

1. For your convenience we accept: Cash, Check, Visa, Mastercard, Discover & Care Credit.
2. We also offer short and long-term financing options (interest-free options may be available).

**For Patients With Dental Insurance**

Dental insurance plans often pay less than the actual fee for service, therefore the patient or guarantor is the responsible party for all dental services provided. Dental insurance, in most cases, is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during your initial appointment or during a separate treatment discussion/consultation appointment. I also authorize to keep my signature on file with Lancaster Smiles in order to process dental insurance claims on my behalf.

**Finance Charge And Fees**

1. Balances in excess of 90 days without prior arrangements will be referred to collections.
2. Returned checks are subject to a $35 accounting fee.

## AUTHORIZATION AND CONSENT

**General Consent To Treatment**

I agree and consent to a dental examination by Lancaster Smiles. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

**Release Of Information**

I authorize Lancaster Smiles to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

**Assignment Of Insurance Benefits** (except for most Delta Dental customers)

Patients are responsible to set up assignment of benefits with their insurance.

I understand and will comply with the Lancaster Smiles **Appointment Policy**.
I understand and will comply with the Lancaster Smiles **Financial Policy**.
I understand and agree to the **General Consent To Treatment**.
I authorize the **Release Of Information**.

X_____ Date: ___/___/_____

**Photography Release**

I authorize Lancaster Smiles to take photographs of me to help me to better understand my current dental condition and possible treatment options. I also authorize Lancaster Smiles to show these photographs to other patients to better explain their treatment options.

X_____ Date: ___/___/_____

# PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Lancaster Smiles to use and disclose my protected health information to carry out:

- Treatment
  (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of your practice.

I have also been informed of, and given the right to review and secure a copy of the Lancaster Smiles *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Lancaster Smiles is not required to agree to these requested restrictions. However, if Lancaster Smiles does agree, Lancaster Smiles is then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Unless you object, Lancaster Smiles may disclose to a member of your family, a relative or any other person you identify, your personal health information that directly relates to that person's involvement in your health care.

I consent to allow Lancaster Smiles to disclose information to _____

_____

X_____ Date: ___/___/_____

Please print patient name: _____

Parent/guardian signature: _____

Please print parent/guardian name: _____

# NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of the Lancaster Smiles Notice Of Privacy Practices. I understand that I may ask any questions I might have regarding this notice.

X_____ Date: ___/___/_____