

Lotus Dental Care

NEW PATIENT INFORMATION

PATIENT INFORMATION – Full Name: _____ **DOB:** _____

If minor parents full name: _____

Social Security#: _____ - _____ - _____

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

Home Phone: _____ Cell phone: _____

Contact options: ___ call ___ text ___email

Employer: _____ Occupation: _____

E-mail Address: _____

Whom may we thank for referring you to our office/how did you hear about our office?

In case of an emergency who may we contact?

Name: _____ Relationship: _____

Phone Number: _____

Preferred pharmacy: _____ Address: _____

BILLING, CREDIT, AND INSURANCE INFORMATION:

(Circle One) Covered/Not Covered by Dental Insurance

Primary Insurance

Dental Insurance Company: _____ Group #: _____ Member ID: _____

Covered by Insurance? (Circle one) YES NO

Policy Holder full name and date of birth- _____ Social Security #: _____

Primary subscriber's (spouse or parent) full name& date of birth-

Secondary Insurance: Do you have dual coverage via your spouse,or parent?

(circle one) YES / NO

Policy Holder's Name: _____ Insured's Social Security #: _____

Insurance Company: _____ Group #: _____ Member ID: _____

Policy Holder's Employer: _____

Do you have a Flexispending or Healthcare Spending credit/debit card (commonly called as FSA or HSA)- YES / NO.

DENTAL HISTORY:

1-What is the reason for your dental visit? _____

2-Have you visited a dental office in the past 3 months ? (Circle one) Yes. No.

If no, when was your last dental visit? _____ Date of last Xrays- _____

Who was your previous dentist?

3-Why did you decide to change dentist? _____

4-Have you ever had an unpleasant dental experience? (Circle one) YES NO (if

Yes, please describe. We want to make sure it doesn't happen again.) _____

5- Do you currently have pain in your teeth or gums? YES / NO

6- Do you have swollen/bleeding gums ? YES / NO.

7-Do you have sleep apnea or do you snore at bedtime? YES / NO.

8- Do you have bad breath? YES /NO.

9- Do you grind /clench your teeth? YES / NO

10- Are you allergic to Novocaine , local
or general anesthesia? YES / NO.

11- Do you have loose teeth or broken fillings? YES/NO.

12-Are you happy with your smile? YES /NO.

If NO, please explain briefly about your expectations-

HIPPA ACKNOWLEDGEMENT

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

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly or indirectly.**
- Obtain payment from third party payers.**
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.**

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent at any time, except the extent that you have taken action relying on this consent.

X _____

LOTUS DENTAL CARE: FINANCIAL POLICY AND AGREEMENT

Thank you for choosing Lotus Dental Care as your dental care provider. We are committed in providing our patients with the highest dental care available. In order that we may have a definite understanding in regard to the payment for dental services the following is our policy:

Our fees accurately represent the quality and the expertise of the specialty work we provide. **Payment is due at the time of service provided** (unless prior financial arrangements are made). We accept cash, check, Visa, Master Card, Discover, American Express and Care Credit.

Lotus Dental will refund any amount paid for treatment that you did not receive. You are responsible to pay in full the amount of treatment you received. We cannot guarantee your treatment will not fail in the future. For that reason we give you a consent form prior to your treatment. Please read it thoroughly and carefully. Lotus Dental Care does not refund any money to any patient who has signed the consent form and dental treatment has been completed / prepared on the patient.

Most dental insurance companies' are not designed to pay for the entire cost of the dental procedures. Most dental insurance plans provide some coverage for dental treatment and the patient is responsible for any balance that is not covered by the insurance company.

Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a part of that contract. **If payment from your insurance company is not received, you will be expected to pay the balance in full.**

We are currently providers of Blue Cross Blue Shield, Humana, MetLife, Cigna, Guardian, United Health Care, Aetna, and Delta Dental. However, we work with all insurance companies and will gladly process the claim for all of our patients. As a courtesy we will also our claim we will either bill a balance due or refund an overpayment to the patient.

Time set aside for our patients is very important to us. We ask for a 24 hour notice of cancellation if it is absolutely needed. We reserve the right to charge a fee for any missed or cancelled appointment without 24 hour notice. Due to the nature of our business, patients come to us on an emergency basis so appointments are critical. Minors should be accomplished by a parent or legal guardian for their appointments /s.

I understand and agree to this Financial Policy and Agreement.

Patient / Guardian Signature

Date