Locust Lane Dental Group

LocustLaneDentalGroup.com
5525 Locust Lane • HARRISBURG, PA 17109
LLDG5525@gmail.com
(717)652-6352

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (M) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

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

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

_____

_____

_____

Parent/Guardian/Subscriber of Insurance

Please complete the following information if the patient is not the subscriber of the dental insurance or is a minor.

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ (Last) _____ (First) ___ (M) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First M

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Patient's relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ *By checking this box now and then signing at the time of my appointment,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance (If no secondary insurance, please skip to medical history):

Name of Insured: _____ _____ ___
Last First M

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Patient's relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Insurance Company Phone Number: _____

Insurance Authorization:

☐ *By checking this box now and then signing at the time of my appointment,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Preferred Pharmacy _____

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *MVP
- ☐ *Pre-med-cephalexin
- ☐ Allergy - Erythro
- ☐ Allergy - Seasonal
- ☐ Arthritis
- ☐ Bisphosphonates
- ☐ Cancer
- ☐ Emphysema
- ☐ Heart Attack
- ☐ HEP B
- ☐ Immunosuppressant
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Pregnancy
- ☐ Sinus Problems
- ☐ Thyroid Problems
- ☐ Ulcers - stomach
- ☐ *Pre-Med - Amox
- ☐ AIDS
- ☐ Allergy - Latex
- ☐ Allergy - Sulfa
- ☐ Artifical Heart Valve
- ☐ Birth Control
- ☐ Crohn's Disease
- ☐ Epilepsy/Seizures
- ☐ Heart Condition
- ☐ HEP C
- ☐ Joint Replacement
- ☐ Low Blood Pressure
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ STD
- ☐ TMJ
- ☐ *Pre-Med - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Other
- ☐ Alzheimers
- ☐ Asthma
- ☐ Bloodthinners
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stroke
- ☐ Tobacco User
- ☐ *Pre-Med - Other
- ☐ Allergy - Codeine
- ☐ Allergy - Penicillin
- ☐ Anemia
- ☐ Autism
- ☐ Bruxisim
- ☐ Dizziness/Fainting
- ☐ Head Injuries
- ☐ Heart Stents
- ☐ HIV
- ☐ latex allergy
- ☐ Migraines
- ☐ Pacemaker
- ☐ Rheumatism
- ☐ Substance abuse
- ☐ Tuberculosis

If any conditions or alerts selected above needs further clarification, please describe below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Have you been exposed to the Corona Virus? * ○ Yes ○ No

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician and phone number:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

_____

_____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

_____

_____

☐ ***By checking this box now and then signing at the time of my appointment, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

_____

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of most recent dental exam and x-rays: _____

How often do you brush and floss? _____

What is your immediate concern? _____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Consent for Services and Financial Policy

If you have dental insurance, we will help you receive maximum benefits. Please inform our front desk staff of all dental insurance plans you are covered by so we can submit your claims properly. Insurance plans vary considerably and we cannot guarantee what part of our services will or will not be covered by your insurance plan. Our office can only provide an ESTIMATE of coverage that is good for one year. You are responsible for any services not covered by your insurance plan. You are also responsible for being aware of your insurance contract maximum and covered benefits. The office is not responsible for keeping track of the amount of insurance money you have utilized for the contract year. YOU ARE ULTIMATELY RESPONSIBLE FOR ALL OF YOUR INSURANCE CO-PAYS AT THE TIME OF YOUR APPOINTMENT. We will expect you to pay any outstanding balances not covered by your insurance before we provide any future treatment. Please contact your insurance carrier or your employer's human resources department if you have any questions or concerns we cannot answer.
PAYMENT: We accept cash, checks, VISA, MasterCard, Discover, and CareCredit. Payment is due at the time of service.
FINANCING: We offer long-term financing options through CareCredit, with one year 0% interest. Please ask our front desk staff for more information.
INFORMED CONSENT: I consent to receive dental care at Locust Lane Dental Group and reserve the right to be informed of any risks, alternative treatment or side effects that I may expect. I certify, to the best of my knowledge, the health history and insurance data I have provided are accurate. In the event that an account becomes more than 90 days delinquent, we reserve the right to turn the account over to collection with an additional fee of $25. If an account is sent to collection, the office also reserves the right to cancel any upcoming appointments for all family members listed on the account and also dismiss any account holders from the practice.

☐ ***By checking this box now, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form until I sign at the time of my appointment.**

Your clear understanding of our financial policy is very important to our professional relationship. We will be happy to discuss any part of our policies in order for our patients to have the best possible experience at our office.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ **By checking this box now, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form until I sign at the time of my appointment.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. By checking this box now, I understand the above information and agree with its contents, and this will serve as my electronic signature until I sign at the time of my appointment.**

Response Date: _____