Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

GENERAL INFORMATION-PLEASE READ

In an effort to avoid any confusion, we would like to provide the following information. It is our hope that this will answer most of the questions or concerns you may have regarding our financial policies. If you have additional questions, please do not hesitate to ask. If you will like a copy of this form, please ask at the front desk.

Payment is DUE ON THE DAY OF SERVICE. Please be prepared to pay for your dental treatment on the day of service. We accept cash, check, Visa, MasterCard, Discover, American Express and CareCredit.

INSURANCE: We will file any DENTAL insurance as a courtesy to our patients. We make no guarantee of coverage by insurance but will estimate insurance benefits. The portion of the treatment not estimated to be covered by the primary dental insurance is due on the day of service. If insurance has not paid after 60 days from the date of service, the balance becomes the responsibility of patient. If you have any questions or concerns regarding your coverage please contact your insurance carrier directly. If you need to know what your insurance will cover for a specific procedure we can file a pre-treatment estimate. ANY PORTION NOT COVERED BY INSURANCE IS THE RESPONSIBITLITY OF THE PATIENT. **If you are a new patient and you do not have your insurance information with you, payment will be due in full.**

Financing: We offer financing with CareCredit. CareCredit provides options that we cannot offer directly through our office. CareCredit offers the flexibility of making low monthly over time. If you are interested in CareCredit, please ask the front desk for more information.

RETURNED CHECKS: There is a $30.00 FEE FOR A RETURNED CHECK. If a person has two returned checks, we will no longer accept personal checks. Payment must be made by cash, credit card or certified funds.

BROKEN/MISSING APPOINTMENTS: In order to provide the best possible service and availability to all of our patients, we reserve the right to charge for missed/cancelled appointments(less than 24 hour notice). Monday appointments must be cancelled by close of business on the prior Thursday to avioid being subject to the fee. Please call us as early as possible to reschedule your appointment. If a patient has two or more broken appointments in a six month period we will not be able to schedule any further appointments. Instead, the patient will be placed on an "on-call" list.

- **Appointments with Dr. Max Frawley:** The fee for missing or cancelling an appointment with less than 24 hour notice will be 20% of the scheduled procedure(s) fee.

- **Appointments with the hygienist:** The fee for missing or cancelling an appointment wotj less than 24 hour notice is $35.00 for a routine cleaning appointment. The fee for other types of hygiene work(ex. Scaling and Root Planning, Full Mouth Debridement) is 20% of the scheduled procedure(s) fee.

LATE ARRIVAL: We regret the late arrivals may not be served in full. If you arrive more than 10 minutes late, your appointment may have to be rescheduled. We will make every attempt to keep your appointment, but we feel we must be fair to the next person scheduled.

PAST DUE ACCOUNTS: When an account is over 90 days past due, it will be turned over to a collections agency. The patient will be placed in a "dismissed" status until the balance, including any fees, is paid in full. Once the balance is paid, payment will be due in full the day of the service for all future appointments and we will no longer accept insurance assignment.

THIRD PARTY ACTION: If the third party action becomes necessary, the financially responsible party agrees to pay for all collection fees to include: 30% collection agency fee, court costs, and attorney fees.

PLEASE SIGN BELOW INDICATION YOU HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS

Signature _____ **Date** _____

PLEASE NOTE: WE RESERVE THE RIGHT TO CHANGE ANY OF THE ABOVE WITHOUT NOTICE

Please Handle Me With Care Form

Print out this form, bring it to your next dental appointment and share the information with your dental team. Put a checkmark next to the statement that concerns you or describes your problem.

_____ I gag easily.

_____ I feel out of control when I'm lying down in the dental chair.

_____ I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.

_____ Pain relief is a top priority for me.

_____ I don't like needles (or I've had a bad reaction to shots).

_____ Please tell me what I need to know about my mouth in order to make an informed decision.

_____ My teeth are very sensitive.

_____ I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.

_____ I don't like cotton in my mouth.

_____ I hate the noise of the drill.

_____ Please respect my time. I don't want to be left sitting in the reception area.

_____ I have difficulty listening and remembering what I hear while sitting in the dental chair.

_____ I have health problems and questions that we need to discuss.

HIPAA DISLOSURE FORM

Dr. Max Frawley Lexington Smile Design Studio

Date_____

Patient's Name_____

Address_____

Phone Number_____

E-Mail Address_____

May we leave a message on your home or cell phone number? _____

I, the patient, herby authorize Lexington Smile Design Studio to release my dental information (appointments, diagnoses, treatments, medications prescribed, surgeries, etc.) via postal mail, telephone, fax or email to my Medical Doctor

Medical Doctor_____

Name of Practice and Phone Number

_____

Friends or Family Members

Name_____Relationship_____

Name_____Realtionship_____

Name_____Relationship_____

Name_____Relationship_____