SEVEN LAKES
FAMILY DENTISTRY
JENNIFER S. MASSEY, DDS

Patient Information

Full Name_____ Preferred Name _____ Birth Date ___ / ____ / ____ Age ____ Today's Date _____

Mailing Address_____ Street Address _____

Home Phone (____)_____ Cell Phone (____)_____ Email _____

Check Appropriate Box: Minor Single Married Divorced Separated Social Security #: _____

Patient's or Parent's Employer_____Occupation_____ Work Phone(____)_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

If Patient is a Student, Name of School/College_____ City_____ State_____

Name of person responsible for this account: _____Relation to Patient _____

Whom May We Thank for Referring You?_____

Person to Contact in Case of an Emergency_____ Phone_____

Insurance Information

Name of Insured_____ Relation to Patient_____

Birth Date_____ Social Security #_____ Employer _____

Employer Address_____ Work Phone _____

Insurance Company_____ Group #_____

Insurance Address_____

If Additional Insurance Policy, Name of Insured _____ Relation to Patient _____

Birth Date_____ Social Security # _____Employer _____

Employer Address _____ Work Phone_____

Insurance Company _____ Group # _____

Insurance Address _____

Dental History

Reason for Today's Visit_____

Former Dentist_____ Date of Last Dental Visit_____ Date of Last X-Ray_____

Check if you have had any of the following:

Bleeding gums	Loose teeth	Sensitivity to cold
Clicking or locking jaw	Missing teeth	Thumb or tongue habit
Food collection	Periodontal treatment	Trauma to your teeth or jaws
Grinding teeth	Sensitivity to heat	Cheek biting habit

How often do you floss?_____ How often do you brush?_____

Medical History

Physician's Name_____ Date of Last Physical_____

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have had any of the following:

- Allergies
- Arthritis, Rheumatism
- Artificial Heart Valve
- Asthma
- Back Problems
- Blood Disease
- Headaches
- Psychiatric Care
- Respiratory Disease
- Cortisone Treatments
- Cough, Persistent
- HIV/AID
- Epilepsy
- Fainting
- Mitral Valve Prolapse
- Pacemaker
- Tuberculosis
- Hemophilia
- Hepatitis
- High Blood Pressure
- Artificial Joint
- Kidney Disease
- Liver Disease
- Tobacco Habit
- Cancer
- Chemical Dependency
- Rheumatic Fever
- Scarlet Fever
- Sinus Problems
- Diabetes
- Swollen Neck Glands
- Thyroid Problems
- Bleeding Abnormalities
- Heart Murmur
- Heart Problems
- Venereal Disease

Medications Currently Taking:

_____

Allergies to Medications:

_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I understand that I am financially responsible for all charges whether or nc paid by insurance. I understand that after a history of 3 broken appointments, I will be charged $25 for all future appointments for which I do not show cancel within 24 hours of appointment time. Payment is due in full at the time of treatment. If you have insurance, we will gladly process your claim b your estimated portion is due at the time services are rendered.

_____ _____

Signature of patient or parent if minor. Date

Informed Consent

I hereby consent for Dr. Massey to perform such dental procedures deemed necessary on myself or my dependent as have been discussed with the doctor. I understand that any evidence of dental disease or abnormality if left untreated will worsen in time. I have been informed of possible alternative treatments, if any exist.

Risks and complications associated with general dental treatment include (but are not limited to): swelling; sensitivity; bleeding; bruising; pain; infection; injury to a nerve resulting in numbness or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth that may persist for weeks, months, or in remote instances, permanently; changes in occlusion (biting); jaw muscle cramps and spasms; referred pain to ear, neck, and head; nausea; vomiting; allergic reactions; delayed healing; temporomandibular (jaw) difficulty; and treatment failure.

Additional risks and complications associated with oral surgery and extractions include (but are not limited to): Post operative discomfort, bleeding, bruising, and swelling that may require several days of recuperation; dry socket; swallowing or aspiration of the tooth; injury to adjacent teeth, crowns, or fillings; post operative infection requiring further treatment; decision to leave a small piece of root in the jaw when its removal would require additional surgery; opening of the maxillary sinus that may require additional surgery; restricted opening of the mouth for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint or fracture of the jaw.

I understand that during the course of dental treatment something unexpected may arise that may necessitate procedures in addition to or different from those planned. I request and authorize the doctor to do whatever deemed advisable to correct the condition. I acknowledge that no guarantees have been made concerning the results of the treatment that I will receive. I agree to cooperate with the doctor and follow post-operative instructions to the best of my ability. I have had an opportunity to discuss with the doctor my medical and health history, as well as my dental condition, the planned procedure and treatment, and the risks and benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment.

If any of the above risks concern you or you do not understand the terminology ask to speak to the doctor or one of the staff for clarification.

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE TERMS AND WORDS WITHIN THE ABOVE CONSENT.

_____ _____

Patient, Parent, or Guardian Date

_____ _____

Witness Doctor

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Seven Lakes Family Dentistry is required by the Health Insurance Portability and Accountability (HIPPA) act of 1996 to inform its patients of their rights and duties regarding the privacy of their health information. This policy is available in the lobby area and is provided to patients at the time of their registration.

I acknowledge that I have received a copy of this notice regarding the use and disclosure of the patient's health information.

Print Name _____ Signature _____

Date _____

I authorize Seven Lakes Family Dentistry to leave messages on voicemail or answering machines at phone numbers I supply.

Yes_____ No _____

I specifically authorize Seven Lakes Family Dentistry to release medical information to the following:

Name	Relationship	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may change this consent at any time. I release Seven Lakes Family Dentistry, its employees and dentistry for any legal responsibilities or liabilities for disclosure of my medical information to the extent authorized here.

Signature	Date	Relationship to patient
_____	_____	_____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice and Consent for Use and Disclosure of Health Information, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please specify) _____

INSURANCE AND FINANCIAL POLICY

Jennifer S. Massey, DDS, PA

We believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

- _____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

- _____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

- _____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

- _____ We require payment in full for your portion AT THE TIME OF SERVICE. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with CareCredit, who offers up to 1 year with no interest to meet your treatment plan needs on approved credit.

- _____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a $25 cancellation fee (cancellation fee starts after a history of 3 appointments which were broken or cancelled less than 24 hours).

- In the event of an emergency after regular business house a $60 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged a $125 after hours emergency fee.

I agree with the above conditions.

Print Name: Date:

Patient/Parent Signature: _____