Lynn Family Dentistry
OUR FAMILY CARING FOR YOURS

Dr. Charles A. Lynn Jr., DDS
Kristin Videla - Office Manager

Patient Health History Form

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Sex:** ◯ Male ◉ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Date of Birth: _____ **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)

Emergency contact Information

Name: _____ (Last) _____ (First) ____ (MI) **Title:** _____ (Mr/Ms/Mrs/etc) **Relation to patient:** _____

Address (if different from patient):

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

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

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

Email: _____

Whom may we thank for referring you to our practice?

_____

Employer Information:

Name: _____ **Your job title:** _____ **Company Phone:** _____

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

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

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ - _____
City State Zip Code

Insured's Birth Date: _____ **Insured's Social Security Number:** _____

Insured's Employer Name: _____ **Insurance Company Phone Number: (** _____ **)** _____

Patient's relationship to insured: ◉ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

ID#: _____ **Group #:** _____

Secondary Dental Insurance

Insured's Name: _____ _____ _____
Last First MI

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ - _____
City State Zip Code

Insured's Birth Date: _____ **Insured's Social Security Number:** _____

Insured's Employer Name: _____ **Insurance Company Phone Number: (** _____ **)** _____

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

Insurance Plan Name: _____

ID#: _____ **Group #:** _____

Insurance Authorization:

☑ **By checking this box,**

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.

DENTAL INFORMATION

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name, Phone number, and address: _____

_____

_____

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

_____

_____

What is the reason for your visit today? _____

_____

Check all that apply:

☐ Have dry mouth

☐ Food gets trapped between any teeth

☐ Have popping/clicking in your jaw (TMJ)

☐ Clench or grind your teeth

☐ Snore or wake up during the night

☐ Gums bleed when flossing or brushing

☐ Had trouble getting numb

☐ Had or have braces (orthodontic treatment)

☐ Teeth are sensitive to hot, cold, biting, or sweets

☐ Have whitened your teeth

☐ Have difficulty chewing

☐ Wear or have worn a bite appliance

☐ Have been treated for gum disease (periodontal treatment)

☐ Difficulty opening/closing mouth

☐ Ear or jaw pain

☐ Loose teeth or broken fillings

☐ Sores or lumps in or near your mouth

☐ Swollen gums

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Do you pre-medicate before receiving dental treatment with any medications? (Clindamycin, Amoxicillin, etc.) If so, please explain why.

_____

_____

_____

Do you have allergies to any of the following?

☐ Seasonal allergies

☐ Latex

☐ Sulfa medications

☐ Local anesthetics

☐ Aspirin

☐ Metals

☐ Codeine

☐ Barbiturates

☐ Erythromycin

☐ Penicillin

☐ Sedatives

☐ Other: _____

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Acid Reflux
- ☐ Artificial Heart
- ☐ Cancer
- ☐ Eating Disorder
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High/Low Blood Pressure
- ☐ Liver Disease
- ☐ Psychiatric Disorder
- ☐ Sinus Problems
- ☐ Ulcers
- ☐ Angina
- ☐ Asthma
- ☐ Dizziness
- ☐ Fainting/Seizures
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ Mitral Valve Prolapse
- ☐ Radiation Treatment
- ☐ Stroke
- ☐ Tobacco/Alcohol Use
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Drug/Alcohol Use
- ☐ Head Injuries
- ☐ Heart Surgery
- ☐ HPV
- ☐ Osteoporosis/Bone Dx
- ☐ Respiratory Problems
- ☐ Thyroid Disease
- ☐ Presently being treated for other illnesses.

If any conditions or alerts need further clarification, please describe below.

_____

_____

_____

_____

If you are currently seeing any specialists (Cardiologist, Oncologist, etc.) please provide their name and phone number below.

_____

_____

_____

_____

FEMALES: Please indicate if you are or may be….

☐ Pregnant ☐ Nursing ☐ Taking birth control

If you are, please explain.

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

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

Are you currently taking any blood-thinning medications such as ◯ Yes ◯ No

Coumadin, Warfarin, Plavix, or Aspirin? If yes, please list below:

List all medications (prescription and non-prescription) and what you are taking them for.

☑ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly.**
There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Sign: _____ **Response Date:** ___/___/_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, unless otherwise indicated.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☑* **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Sign: _____ **Response Date:** __/__/____

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 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 all reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf.

☑* **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. This will serve as my electronic signature.**

Name of person filling out this form:

_____

_____

Relationship to patient:

☑ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Sign: _____ **Response Date:** __/__/____

HIPAA Acknowledgment

I_____authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.) _____

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, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Sign: _____ **Response Date:** __/__/____

Trojan Professional Services, Inc. ("Trojan") is not a law firm, does not employ an attorney and does not provide legal advice. The below shall not be considered legal advice. Trojan offers the below as a possible starting point in developing financial consent language in your practice. In providing the below, Trojan strongly recommends that you consult with an attorney of your choosing to review the offered financial consent language to insure that any financial consent language that you use is consistent with applicable federal, state, city and other laws and regulations. **If you elect to use all or any portion of the below, you agree not to seek damages from Trojan, or seek to hold Trojan liable, relating to or arising out of any claims or demands of any kind based on the use of any portion the below language, whether initiated by you or a third party (including but not limited to claims for reimbursement or indemnity).**

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $25.00 returned check fee. Any account balances that remain unpaid for 90 days from the date of service shall accrue interest at the rate of 15 percent (15%) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $35.00. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient: _____ Date: _____

Print Name: _____

Guardian/Responsible Party, if minor:_____ Date: _____

Print Name: _____