LANE & ASSOCIATES
Family Dentistry

WELCOME TO OUR PRACTICE

Welcome to Lane & Associates Family Dentistry where *We love to make you smile!*

We would like to thank you for allowing us to treat you or your loved one as our patient and we are pleased to meet all your dental needs. We will always do our best to give you the most up-to-date and professional care available! Here is a list of our office policies and procedures:

If you have active tuberculosis, persistent cough (greater than a 3-week duration, a cough that produces blood, or been exposed to anyone with tuberculosis) please stop and return this form to the receptionist.

_____ initial As a courtesy, **Lane & Associates Family Dentistry** will file your dental claim with your insurance company. Your deductible and co-pay, or any portion not covered by your insurance company, is due ***at the time of service***. For those patients without insurance coverage, **you will be responsible for your payment in full on the day of treatment.**

_____ initial **Broken appointments are very costly and inconvenient.** If you are unable to keep your appointment, please inform us at least twenty-four (24) hours in advance. Two or more broken appointments will lead to you and your family being dismissed from our practice. An unconfirmed appointment may run the risk of being rescheduled.

_____ initial If you have Medicaid, **you must have your current Medicaid card with you.** Also, if you are twenty-one (21) years of age or older you are responsible for the $3.00 co-pay. If you do not have a current card, we reserve the right to reschedule your appointment.

_____ initial If you are **more than fifteen (15) minutes late for your appointment,** you may be rescheduled for another day. This will be considered a broken appointment and could result in a $25 fee.

_____ initial **All patients under the age of eighteen (18) are required to have a parent or legal guardian present** with them at each appointment. They will not be seen or treated in the absence of a parent or legal guardian without a signed consent form. Please ask our front desk for more information or to request a form.

_____ initial In the event your payment is past due, **you are responsible to pay the cost of collecting any debt owed on your account.** This includes all attorney's fees, late fees, and interest to be charged at one percent per month.

By signing below, you also agree that you have read and understood our **Notice of Privacy Practices**. A copy of this agreement is available upon request.

_____ Signature of Patient or Responsible Party

_____ Date

Office Only: We were unable to obtain written acknowledgement of receipt of Privacy Practices because:
☐ An emergency existed, and a signature was not possible at the time. ☐ The individual refused to sign.
☐ A copy was mailed with a request for a signature. ☐Other: _____

Employee: _____ Signature: _____ Date: _____

Authorization for Release of Information

Name of Patient: _____ **Date of Birth:** _____

Lane & Associates Family Dentistry is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Patient Signature: _____

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
□ Voice Mail	□ Results of lab tests/x-rays □ Other_____
□ Spouse (provide name & phone number) _____	□ Financial □ Medical as follows: _____
□ Parent (provide name & phone number) _____	□ Financial □ Medical as follows: _____
□ Other (provide name & phone number) _____	□ Financial □ Medical as follows _____

How did you select Lane & Associates Family Dentistry?

Please select the option that applies:

☐ Family Member/Friend Referral
☐ Dentist Referral
☐ Accepts My Insurance
☐ Inter-Office Transfer
☐ lanedds.com (website)
☐ Google Search
☐ Yelp Search
☐ Bing Search
☐ Phone Book
☐ Google Maps
☐ Newspaper/Magazine
☐ Mail Flyer
☐ Open House
☐ Social Media – Which one? _____
☐ Office Appearance/Exterior
☐ Fair/Festival – Which one? _____

Patient Information & Medical History

Patient Information

Name of Child: Date of Birth:

Last First MI

Address: City: State: Zip:

Social Security Number: Sex: Age: Race: Weight:

Mother's/Guardian Name: Social Security Number:

Address: City: State: Zip:

Primary Phone Number: Secondary Phone Number: Email:

Father's/Guardian Name: Social Security Number:

Address: City: State: Zip:

Primary Phone Number: Secondary Phone Number: Email:

Responsible Party:

Name: Relationship: Phone: Email:

Last First MI ( )

Address: City: State: Zip:

Date of Birth: Employer: Social Security: Driver's License Number:

Insurance

Name of Insured: Date of Birth: Relationship to Patient:

Last First MI

Employer: Insurance Company: Social Security:

Address: Phone:

City Zip ( )

Group Number: Policy Number:

If you have additional dental insurance, please notify our staff.

Dental Insurance

As a courtesy, we will be happy to file your insurance claims as well as obtain all plan information and provisions. It is our pleasure to assist you with this; however, we encourage you to become familiar with your coverage and benefit period allowances. We strive to assist you in utilizing and maximizing your coverage and recommend that you also maintain knowledge of your benefits used throughout the benefit period.

Please understand that your insurance is a contract between you, your employer, and your insurance company. Thus, we cannot speak on behalf of your insurance company. We will gladly act as your advocate, but we cannot be responsible for settling any disputed claims or coverage. We thank you for choosing us to provide excellent dental care for you, and we look forward to taking care of your dental needs.

If we do not receive payment from your insurance carrier **within forty-five (45) days,** we will notify you. Failure of your insurance carrier to reimburse our office **within sixty (60) days** will result in our billing you directly for the remaining balance. **Please remember that you are ultimately responsible for your bill.**

_____ _____

Signature of Patient or Responsible Party Date

Health History: Please answer the following questions in regard to your child.

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV + / AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (Teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	

Child's Physician Name: Phone: ( )

Medical Information

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?	☐	☐	☐
If yes, please list: _____			
Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	☐	☐	☐
Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	☐	☐	☐
How would you describe the child's eating habits? _____			
Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	☐	☐	☐
Has the child ever been hospitalized?	☐	☐	☐
Does the child have a history of any illnesses? If yes, please list: _____	☐	☐	☐
Has the child ever received a general anesthetic?	☐	☐	☐
Does the child have any inherited problems?	☐	☐	☐
Does the child have any speech difficulties?	☐	☐	☐
Has the child ever had a blood transfusion?	☐	☐	☐
Is the child physically, mentally, or emotionally impaired?	☐	☐	☐
Does the child experience excessive bleeding when cut?	☐	☐	☐
Is the child currently being treated for any illnesses?	☐	☐	☐
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	☐	☐	☐
Has the child had any problem with dental treatment in the past?	☐	☐	☐
Has the child ever had dental radiographs (x-rays) exposed?	☐	☐	☐
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐	☐
Has the child had any problems with the eruption or shedding of teeth?	☐	☐	☐
Has the child had any orthodontic treatment?	☐	☐	☐
What type of water does your child drink? ☐ City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water			
Does the child take fluoride supplements?	☐	☐	☐
Is fluoride toothpaste used?	☐	☐	☐
How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	☐	☐	☐
Does the child such his/her thumb, fingers or pacifier?	☐	☐	☐
At what age did the child stop bottle feeding? Age _____ Breast Feeding? Age _____			
Does the child participate in active recreational activities?	☐	☐	☐

Parental Consent

I request and authorize Lane & Associates to perform the treatment and procedures outlined on treatment plan for: _____

I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by the clinical faculty to diagnose and/or treat the patient's dental needs.

- I have had explained to me, and I have had sufficient opportunity to discuss the patient's dental condition and needs, the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.
- The usual and most frequently occurring risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain and/or discomfort during the following treatment swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.
- I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to, or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient will receive.
- I understand that at Lane & Associates that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. We will provide a clinical environment that is likely to help children to learn to cooperate during treatment. To accomplish this, the patient's behavior will be guided using praise, explanation, and demonstration of procedures and instruments, using variable voice tone and loudness.
- I understand that should the patient become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot safely be provided. During such disruptive behavior, it may be necessary for the assistant to hold the patient's hands, stabilize the head, and/or control leg movements. If we still cannot provide treatment, we will reschedule the patient.
- All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.
- I understand that I may revoke this consent, in writing at any time, and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
- I confirm that I have read and understand this form, or it was read to me, and that all blanks were filled and all inapplicable paragraphs, if any, were stricken prior to my signing below.
- **Would you consent to a blood test (at our expense) if the Doctor or Staff member suffers a needle stick or puncture wound?** YES / NO

_____ _____

Signature of parent, legal guardian, or care taker — Date

_____ _____

Printed Name — Date

_____ _____

Witness — Date

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient/Legal Guardian Date

Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name: _____ **Height:** _____ **Weight:** _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations (in contrast to just feeling tired)?

0 = I would never doze **2** = I have a moderate chance of dozing
1 = I have a slight chance of dozing **3** = I have a high chance of dozing

	Situation	Chance of Dozing
1.	Sitting and reading	_____
2.	Watching TV	_____
3.	Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4.	As a passenger in a car for an hour without a break	_____
5.	Lying down to rest in the afternoon when circumstances permit	_____
6.	Sitting and talking to someone	_____
7.	Sitting quietly after lunch without alcohol	_____
8.	In a car while stopped for a few minutes in traffic	_____
	Total Score	_____

	Have you ever been diagnosed with:	**Yes**	**No**
1.	Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2.	Mood Disorders/Depression	☐	☐
3.	Insomnia	☐	☐
4.	Hypertension (high blood pressure)	☐	☐
5.	Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6.	History of Stroke	☐	☐
7.	Sleep Apnea	☐	☐
	If yes: Did you try to use CPAP?	☐	☐
8.	TMJ problems significant enough to require treatment	☐	☐
9.	Gastric Reflux (GERD) or Heartburn	☐	☐

	Do you suffer from any of the following conditions?	**Yes**	**No**
1.	Snoring on a regular basis	☐	☐
2.	Feeling tired or fatigued on a regular basis	☐	☐
3.	Clenching or grinding your teeth (bruxism)	☐	☐
4.	Having frequent headaches	☐	☐
5.	Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6.	Anyone in your family having sleep apnea	☐	☐
7.	Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children age 16 and under (filled out by parent or guardian)

	Does your child suffer from any of the following?	**Yes**	**No**
1.	Snoring/noisy breathing while sleeping	☐	☐
2.	Grinding his or her teeth	☐	☐
3.	Wetting the bed	☐	☐
4.	Having difficulty in school/learning	☐	☐
5.	Being treated for ADD or ADHD	☐	☐
6.	Breathing primarily through their mouth	☐	☐
7.	Having frequent nightmares/night terrors	☐	☐
8.	Having frequent ear aches	☐	☐

DENTIST'S EXAM FINDINGS AND SIGNATURE:

☐ **Evidence of Bruxism** ☐ **Scalloping of the tongue** ☐ **Crowded airway** ☐ **Tori or Bone Loss** ☐ **Anterior wear**
☐ **Occlusal Wear** ☐ **Macroglossia** ☐ **Restricted Arch** ☐ **Retrognathia / Class II** ☐ **Mallampati** _____

_____ _____
Dentist Signature Date