Argyle Dental Connection
Family, Cosmetic & Implant Dentistry

Patient Information

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete our patient information form so that we can provide the best care possible for you.

NAME: _____ **DATE:** _____
Last First Middle Initial
PREFERRED NAME: _____ ☐ Male ☐ Female ☐ Child ☐ Single ***EMAIL***_____

ADDRESS: _____
Street City State Zip
BIRTHDATE: _____**PHONE Home**: _____ ***Cell*:** _____
MM/DD/YY
DRIVERS LICENSE #: _____**SOCIAL SECURITY #:** _____

PLACE OF EMPLOYMENT: _____ **Work #:** _____

Has any member of your family ever been treated in our office? ☐ Yes ☐ No If Yes, who? _____

Whom may we thank for referring you to our office? (Check all that apply)

☐ Newspaper/ Source Book ☐ Sign ☐ Yellow Pages ☐ Banner ☐ Internet Search ☐ Gift Card

☐ Personal Referral/Friend: _____ ☐ Another Dr. _____

Insured Information	**Responsible/Billing Party Information**
Relation to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other	Relation to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other
Last: First MI	Last: First MI
Address City ST ZIP	Address City ST ZIP
Home/Cell # Birth date:	Home/Cell # Birth date:
Insured SSN: or Insured's ID #	Email: Driver License #
Employer: Insurance Plan Name:	Work #:
Insurance Phone #: Group #:	

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME: _____ Relation to Patient: _____Phone #: _____

May we leave messages announcing our office name in regards to appointments, treatment, and/or insurance/financials on your voicemail? (circle one**) Yes No*

Please continue to next page…

Medical History

Who was your previous dentist? _____
When was the last time you had dental x-rays taken? _____
Have you ever had a major operation? ☐ Yes ☐ No Describe? _____
Have you ever had complications following dental treatment? ☐ Yes ☐ No Explain _____
_____
Are you under the care of a physician? ☐ Yes ☐ No Explain? _____
Name of physician: _____ Phone #: _____

Health Information

☑ *Please indicate Yes or No for each option below. The hygienist will clarify any questions you may have.*

YN	YN	YN	YN
☐☐ADD	☐☐Heart Disease	☐☐PREMED	☐☐Aspirin Allergy
☐☐Arthritis	☐☐Heart Murmur/ MVP	☐☐Sickle Cell Anemia	☐☐Bactrim Allergy
☐☐Artificial Joints	☐☐High Blood Pressure	☐☐Sinus	☐☐Cephlesporin Allergy
☐☐Asthma	☐☐Hemophiliac	☐☐Rheumatic Fever	☐☐Codeine Allergy
☐☐Anemia	☐☐Hepatitis – A B C	☐☐GERD/Reflux	☐☐Demerol Allergy
☐☐Blood Disease	☐☐Implants	☐☐Stroke	☐☐Erythromycin Allergy
☐☐Blood Thinner	☐☐IV Bisphosphonates	☐☐Taken Phen-Fen	☐☐Iodine Allergy
☐☐Blood Transfusion	☐☐Kidney Disease	☐☐Tuberculosis	☐☐Penicillin Allergy
☐☐Cancer	☐☐Liver Disease	☐☐Venereal Disease	☐☐Sulfur Allergy
☐☐Radiation Therapy	☐☐Lupus	☐☐AIDS/HIV	☐☐Steroid Allergy
☐☐COPD	☐☐Metal Sensitivity	☐☐HPV	☐☐Tetracycline Allergy
☐☐Diabetes Type I II	☐☐Multiple Sclerosis	☐☐White Coat HBP	☐☐Vicodin Allergy
☐☐Emphysema	☐☐Mental Disorders	☐☐OTHER MEDICAL	☐☐Latex Allergy
☐☐Epilepsy/ Seizures	☐☐Nervous Disorders	CONDITIONS:	☐☐OTHERALLERGIES
☐☐Excessive Bleeding	☐☐Pacemaker	☐☐_____	☐☐_____
☐☐Fainting	☐☐Parkinson's	☐☐_____	☐☐_____
☐☐Glaucoma/Mac Deg	☐☐Physical Challenge	☐☐_____	☐☐Smoker
☐☐Head Injuries	☐☐Pregnant (Currently)		☐☐Tobacco Use

SLEEP APNEA

☐☐Has anyone ever informed you that you snore?
☐☐Do you doze off during the day or at the wheel?
☐☐Do you wake up tired or with a headache?
☐☐Do you have problems concentrating or focusing?
☐☐Do you wear a CPap/BiPap

ESTHETICS

☐☐Are you happy with the color of your teeth?
☐☐Are you happy with the shape/size?
☐☐Are you interested in teeth whitening?
Ask about our program ***Whitening For Life™***

MEDICATIONS

Name	Dose	Times/ Day

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or medications, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payers or other health care professionals.

X _____
Signature of Patient / Guardian Date

I hereby authorize this office to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependants through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to this dental office. This "signature on file" will be valid from this date and shall end when authorized through written notice to this office. A photocopy of this document may act as an original.

X _____
Signature of Patient / Guardian Date

Please continue to next page…

Argyle Dental Connection

Financial and Insurance Policy

Our primary responsibility to you is to provide quality dental care. To maintain this standard of care, we believe it is in the best interest of everyone to establish a patient account policy up front to avoid any misunderstandings. We will provide you with a written estimate of your financial investment prior to any treatment being rendered. Treatment estimates quoted are good for 90 days from the date of the estimate. Emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

1. PAYMENT IS EXPECTED ON THE DATE OF SERVICE. In some instances, we may ask that you prepay for your dental services to reserve special appointment dates and/or times. Please indicate the method you intend to use to pay for your dental treatment, including your co-payment:

☐ **Credit Card** ☐ **Cash** ☐ **Check** ☐ **Care Credit** ☐ **I would like to know more about financial options**

2. DENTAL INSURANCE: We want to help you maximize your insurance benefits. As a service to you, we are happy to file your insurance claims. Please remember, dental insurance does not always cover the cost of your dental treatment as anticipated. While dental/medical costs have increased in the past 10 years, dental insurance benefits have remained relatively unchanged over the past 40 years. We do not allow insurance companies to dictate the course of treatment for our patients. Rest assured that we will recommend a treatment plan that is appropriate for your diagnosis regardless of what your insurance might or might not reimburse. We have a commitment to treat you, not your insurance company. In consideration for the professional service rendered to me, or at my request, by the Doctor, I agree to pay the agreed value of services to Donald Lanning, DDS, or his assignee, at the time services are rendered, or within five (5) days of billing if credit shall be extended. All financial arrangements must be made with our financial coordinator in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. In the case of minors or separated or divorced parents, it is the responsibility of the parent bringing the patient into the office for treatment to arrange appointments and keep treatment and all accounts current.

We are more than happy to request that your insurance benefits be sent directly to our office with your consent and if your plan offer this service. Unfortunately, there are a few instances in which we cannot accept assignment of benefit. Some carriers will not send payment to the provider, even when we request that they do so. There are also insurance plans that are set up to reimburse on a “fee schedule”, rendering estimates of coverage impossible. Finally, COBRA, and some other plans that are also month to month insurance, therefore, we will ask for payment in full within 25 days of the date of service. As always, we are happy to file your claims as a service to our patients.

Many insurance plans have frequency limitations, alternate benefit clauses, payment or fee tables, and other exclusions that **may limit your coverage.** The patient is financially responsible for cost of treatment. As a courtesy, we will provide an *estimate* of your dental insurance assistance. If your insurance carrier does not pay as anticipated, our financial policy requires that the remaining balance be paid in full within 15 days of the final billing date. Additionally, a claim unpaid within 60 days of the filing date, or has been denied by the insurance carrier will become the patient’s responsibility.

3. Additional Account Charges: We reserve the right to add a service charge to overdue accounts. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. A charge of $30 will be applied to all returned checks. We require that returned checks and fees be cleared by cash, certified funds, or credit card.

4. Secondary Insurance: As a courtesy, we will file your primary insurance claims only. We will provide a physician’s walk out statement with CDT codes for you to file your secondary insurance claim.

By signing below, I acknowledge and agree to Argyle Dental Connection’s financial policies. Even if I do not currently have dental insurance, I will promptly notify the business office with any changes in my phone numbers, mailing address, and dental insurance coverage and/or eligibility status. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees to effect collection of this account or future outstanding accounts.

X _____ Date: _____

Signature of Patient/Parent/Guardian

Please continue to next page…

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: *«LName», «FName» «MI»* **Address**: *«Street» «Street2» «City» «State» «Zip»*

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payments, activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Privacy Practices is framed on the wall next to our inner offer door.

We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, *«FName»,* have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing the consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

CONSENT FOR SERVICES

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give my permission for my dentist and dental team to use my photographs for in-office patient education.

I understand that patient names will be posted in our appointment books, on computer screens, and on schedules posted in treatment areas of the office, and that patient privacy will be maintained as much as possible.

I grant my permission to you or your assignee, to telephone me at home, my cell, or at my work to discuss matters related to my treatment and billing. I understand that I may receive a text message and\or email message to remind me of an appointment.
_____ *Please initial*

X _____ Date: _____
Signature of patient/parent/guardian