Eureka Family Dental
Thomas R. Lemonds D.D.S.
13046 Eureka Rd, Southgate MI 48195
734-282-4838

Patient Registration

Patient Information:

First Name: ____________________________ Last Name ____________________________MI _____ Preferred Name: ____________

Address: ____City, State, Zip ____

Home Phone:__________________________ Cell Phone: ________________________Work Phone: _________________________

Sex: ____ Female ____ Male Marital Status: ___ Married ___ Single ___ Divorced ___ Separated ___ Widowed

Birth date: __________________ Social Security #: _____________________________ Drivers Lic #: ___________________________

E-mail:____ I would like to receive e-mail correspondences ___yes ___no

Patient is : _____ Responsible Party _____ Policy Holder

Employment Status: ____ Full Time ____ Part Time ____ Self Employed ____ Retired ___Unemployed

Student Status: ____Full Time ____ Part Time

Responsible Party: (if different than the patient)

First Name: ________________________________ Last Name: ____ M I: ____________

Address: ____City, State, Zip ____

Home Phone:___________________________ Cell Phone: ________________________Work Phone: ________________________

Birth date: ___________________Social Security #:____________________Drivers Lic#: ____________________________________

Responsible Party is: ____ Primary Policy Holder for patient _____ Secondary Policy Holder for patient

Employment Status: ____ Full Time ____ Part Time ____ Self Employed ____ Retired _____ Unemployed

Primary Insurance Information:

Name of Insured: ____ Relationship to Insured: __Self __Spouse __Child __ Other

Primary Member ID: ____Carrier ID: _____________________________________

Insured Social Security #: ____ Insured Birth date:_____________________________

Employer: ____ Insurance Company: ____

Address: ______________________________City, State, Zip: ____

Secondary Insurance Information:

Name of Insured: ____ Relationship to Insured: __Self __Spouse __Child __ Other

Primary Member ID: ____

Insured Social Security #: ____ Insured Birth date:_____________________________

Employer: ____ Insurance Company: ____

Address: ______________________________City, State, Zip: ____

Emergency Contact:

Name ____ Relationship: _________________ Phone #: ________________________

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Initial Visit Dental History

Patient Name: ______________________________________ Date:_____________________

Reason for Today's Appointment: ____

Date of Last Dental Visit: _________________Date of Last Dental X-Rays:________________

Reason for last Dental Visit: ____

1. Are you happy/satisfied with the condition and/or appearance of your teeth or smile? Yes No

2. What would you change (if anything) about the condition of your teeth/smile? ______________

____

3. Have you ever had (or been told you had) any of the following (please circle yes or no):

Regular dental checkups	yes	no	TMJ or jaw pain	yes	no
Fillings or cavities	yes	no	Grinding or clicking of your jaw	yes	no
Crowns/Caps	yes	no	Bleeding Gums	yes	no
Fixed Bridges	yes	no	Chronic Bad Breath	yes	no
Implants	yes	no	Anxiety about dental treatment	yes	no
Dentures or Partial Dentures	yes	no	Sensitive teeth to cold or sweets	yes	no
Orthodontic Treatment	yes	no	Snoring Problems	yes	no
Periodental Treatment	yes	no	Chronic cold sores and Lesions	yes	no
Gum Surgery	yes	no	Food caught between your teeth	yes	no
Wisdom teeth extracted	yes	no	Do you brush your teeth regularly	yes	no
Other teeth extracted	yes	no	Do you floss regularly	yes	no
Loose teeth as an adult	yes	no	Drink carbonated beverages	yes	no

4. Is there anything else that you would like us to know about the condition of your teeth or today's appointment?

____

____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report and update any changes to my dental or medical status.

____ _________________________

Patient or Patient's Authorized Representative's Signature Date

Eureka Family Dental

Thomas R. Lemonds D.D.S.

Patient Medical History

PATIENT NAME: ____________________ Birth Date :____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: ____________________

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: ____________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing biophosphonates? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances Yes No

Are you taking any medications, pills, or drugs? Yes No If yes, please list: ____________________

Do you need to pre-medicate? Yes No If yes, please explain: ____________________

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: ____________________

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ____________________

Comments: ____________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE ____________________

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Financial Policy

Thank you for choosing Thomas R. Lemonds D.D.S. as your dental care provider. Our goal is to provide you and your family with optimum quality dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Financial Agreement:
Patients are expected to pay for our services at the time they are rendered, unless previous arrangements have been made. We accept Cash, Check, American Express, Master Card, Visa and/or Discover. We also offer CARECREDIT, which is a financing option available for healthcare expenses. Patients with insurance will be responsible for co-pays and deductibles at the time of treatment. In addition to paying through the mail, credit card information may also be called in to the office during regular business hours.

Dental Insurance
As a courtesy to you, we will complete your insurance claim and submit it to your insurance company. You are responsible for providing us with accurate and up-to-date insurance information. It is especially important to have the correct Insurance company name and your ID number. Please bring your insurance card to appointments.

Insurance plans vary greatly in what they cover. Benefits vary in what procedures are covered, deductibles, the percentage of coverage, maximums and the fee schedule that is used by each company. There may be waiting periods and exclusions to treatment. We will do our best to help you determine your coverage, but it is ultimately up to you to know what your benefits are. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the balance amount left on the account at that time.

If your insurance has not paid ninety (90) days after treatment was performed, you will be responsible for the amount due, and also will be responsible for contacting your insurance company to settle any eligibility or other issue. Our office is unable to enter into a dispute with your insurance company over claims, eligibility or other issues - this is your responsibility, as the contract is between the insurance company and you. We will provide the necessary documentation to you, or if your insurance company requests information to help settle the claim. If you have paid for treatment out of pocket once this 90 day period has commenced, and we later receive payment from the insurance company for the services you paid for, we will gladly and promptly reimburse you for those fees paid by you..

Minor Children:
The adult accompanying the minor is responsible for the payment on the account. In the case of divorced parents, the adult accompanying the minor is responsible for all costs incurred. We will not get involved in disputes between parents, but will provide any documentation that is needed.

Broken Appointments
Once an appointment has been scheduled, that time is reserved specifically for you. Please allow at least 2 business days to change or cancel an appointment, so that we may care for all of our patients in a timely manner. You may be charged a $35.00 fee for appointments broken without 48 hour notice.

Payments
An invoice with what you owe will be issued after the insurance carrier has paid its portion of your treatment. Balances owed by you are due within 30 days of the statement date, unless other arrangements have been made. Balances over 30 days will be charged 1.5% per month (18% annually). Balances which are past due over 90 days will be handled by an outside collection agency.

I have read, understand, and accept the financial policy for the office of Thomas R. Lemonds D.D.S.

Patient Name (please Print) ____

Signature of patient or parent ____Date ______________

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Patient Name (print) ____ Date of Birth_____________

RECEIPT of HIPAA PRIVACY NOTICE

Thomas R. Lemonds D.D.S. is committed to maintaining the integrity of your protected health and dental information and complying with all applicable state and federal regulations regarding them. The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect as of April 13, 2013. In support of our policy of complying with all applicable regulations. Thomas R. Lemonds D.D.S. will provide you with a copy of the HIPAA Notice of Privacy Rights, upon request. While not required in order to receive treatment in our office, we are obligated under the federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you. I have read and agree to the above:

* ____ ______________________
Patient (or Representative) Signature Date

Refusal to sign the acknowledgement does not prevent you from being treated

Were you offered a copy of our HIPAA Policy? yes no

Staff: Check if Patient declines to sign acknowledgement __________

Staff Signature if checked above: ____ Date: _________________________

CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released by Thomas R. Lemonds D.D.S. to:

1. ____ Relationship: ________________ Phone: __________________
2. ____ Relationship: ________________ Phone: __________________
3. ____ Relationship: ________________ Phone: __________________

I understand that I have the right to:
1. Revoke this authorization by sending written notice to this office and that such revocation will not affect this office's previous reliance on the use or disclosures pursuant to this authorization.
2. Inspect a copy of this office's Patient Health Information being used or disclosed under federal law.
3. Refuse to sign a copy of this authorization
4. Receive a copy of this authorization
5. Restrict what is disclosed in this authorization

COMMUNICATION INFORMATION FOR THOMAS R. LEMONDS D.D.S.

How may we contact you?

Allow phone calls to your home phone? yes no Allow emails? yes no
Allow phone calls to your cell phone? yes no Allow text messages? yes no
Allow postal mail? yes no Allow voice messages? yes no

May we leave messages? yes no

I agree to all of the information listed above.

____ ______________________
Patient (or Representative) Signature Date