Lambourne Family Dental

New Patient Information

( ) Steven Lambourne, DDS

( ) New Patient ( ) Existing

Patient Name: _____ Appt. Date: _____ Appt. Time: _____
First MI Last

Address: _____Apt # _____ City _____State_____ Zip Code _____

Phone # Home: ( ) _____-_____ Work: ( ) _____-_____ ext. _____ Cell: ( ) _____-_____

E-mail Address: _____ Text to confirm appointment YES / NO

Birth Date: _____ Social Security # _____- ___ - _____ Gender: *Male/Female* Family Status: *S/M/D/W*

In case of an Emergency, who should we notify? Name: _____ Phone # _____

Name of second family contact in case of emergency: Name_____ ( ) _____-_____

Patient, Spouse or Responsible Party

The following is for: the Patient ( ) the Patient's Spouse ( ) the person responsible for payment ( )

Name: _____ Birth Date: _____ Social Security # _____-___-_____

Male ( ) Female ( ) Married ( ) Single ( ) Child ( ) Other ( ) _____

Address: _____Apt # _____ City _____State_____ Zip Code _____

Phone # Home: ( ) _____-_____ Work: ( ) _____-_____ ext. _____ Cell: ( ) _____-_____

Employment Information

Employer: _____ Occupation: _____ Title: _____

Address: _____Apt # _____ City _____State_____ Zip Code _____

Phone # Work: ( ) _____-_____ ext. _____ Work E-mail Address: _____

Referral Information

How did you hear about our practice: _____

I hereby certify that the answers to the above questions are accurate to the best of my knowledge.

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable in full at the time of service. There will be a fee, of $35 per hour missed, assessed for missed appointments or appointments canceled with less than 24 business hours notice.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is responsible for payments of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collection received to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. The patient also understands that they are responsible for any services not paid for by their insurance company.

A service charge of 1.5% per month (annual percentage rate 18%) on the unpaid balance will be assessed on all accounts exceeding thirty days from the date of service. Fee estimates for 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 or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services, or within thirty days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of further term or condition, and I further agree to pay all costs and reasonable attorneys fees if suit be instituted hereunder to collect monies owed by me, including interest chargers, processing fees or commission (up to an additional 40% collection fee) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at homes, cellular phone or workplace to discuss matters relating to the form. I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitles, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Lambourne Family Dental.

I certify that I have answered all questions on the forms accurately and I hereby agree to abide by the conditions outlines therein.

_____ _____ _____

Signature of patient, parents, guardian or representative | Date | Relationship to patient

Acknowledgment of Receipt of Notice of Privacy of Practices

I, _____, have received a copy of this office's Notice of Privacy and Practices
Print Name

_____
Signature of patient, parents, guardian or representative

Date _____ Relationship to Patient _____

Consent to Proceed

I authorize Dr. Lambourne or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleaning and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician and/or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the pas, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complication of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ _____

Patient Name Signature of Patients, Parents or Guardian

_____ _____

Date Signature of Dentist or Staff

Review of Medical History

I have reviewed the foregoing Medical History (next page) and find it to be unchanged and accurate except as noted:

_____ _____ _____

Signature of Patient, Parents or Guardian Date Updated Information

_____ _____

Signature of Dentist or Staff Date

Medical History

Name: _____

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: _____
Are you taking any medications, pills or drugs?	○ Yes ○ No	If yes, please explain: _____
Do you take or have you taken Phen-Fed or Redux?	○ Yes ○ No	_____
Are you on a special diet?	○ Yes ○ No	_____
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	

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

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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 Intest 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 Problems	☐ Yes ☐ No	Frequent Headache	☐ 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 _____