LAKE COUNTRY DENTAL
RAY D. SNIDER, D.D.S., and ASSOCIATES
Cosmetic • Family • Implant Dentistry • Orthodontics

WELCOME TO OUR PRACTICE

Patient Information

Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: HM (_____)_____ WK (_____) _____ CELL (_____) _____

Birthdate: _____ Social Security #: _____ Age: _____

Driver License #: _____ State: _____ Please circle: Male / Female Married / Single / Divorced / Widowed

Email: _____

Responsible Party Information

Name: _____ Email: _____

Address: _____ City/State/Zip: _____

Phone: HM (_____) _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____ Age: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

How would you like to pay for today's visit? Credit Card / Check / Cash / Monthly Payments with approved credit

Insurance Information

Primary Insurance Co.: _____ Phone: (_____)_____

Employer: _____ Group #: _____ Employee Name: _____

Birthdate: _____ S.S.#: _____ Employee #: _____

Secondary Insurance Co.: _____ Phone: (_____)_____

Employer: _____ Group #: _____ Employee Name: _____

Birthdate: _____ S.S.#: _____ Employee #: _____

Getting To Know You

Are other members of your family patients at our office? YES / NO

Name(s): _____ Relationship: _____

Name(s): _____ Relationship: _____

How did your hear about our office? _____

Person to contact for emergency: _____ Phone: (_____) _____

Address: _____

Dental Health History (Confidential)

Reason for today's visit?: _____

Why did you leave your former dentist? _____ Date of last x-rays: _____

Do you have problems with any of the following:

____ Mouth Odor	____ Grinding Teeth	____ Heat Sensitivity
____ Bleeding Gums	____ Loose Teeth or Broken Fillings	____ Sweet Sensitivity
____ Clicking or Popping Jaw	____ Peridontal Disease/Treatment	____ Sensitivity to Biting Pressure
____ Food Collection Between Teeth	____ Cold Sensitivity	____ Sores or Growths in Mouth

How often do you floss? _____ How often do you brush? _____

Medical History (Confidential)

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? YES/NO If yes describe: _____

_____

Have you ever had a blood transfusion? YES/NO If yes give approximate date(s): _____

(Women) Are you pregnant? YES/NO Nursing? YES/NO Taking Birth Control Pills? YES/NO

Check if you have or have had any of the following:

____ AIDS	____ Cortisone Treatments	____ Hepatitis Type _____	____ Rheumatic Fever
____ Anemia	____ Cough, Persistent	____ High Blood Pressure	____ Scarlet Fever
____ Arthritis, Rheumatism	____ Cough up Blood	____ HIV Positive	____ Shortness of Breath
____ Artificial Heart Valves	____ Diabetes	____ Jaw Pain	____ Skin Rash
____ Artificial Joints	____ Epilepsy	____ Kidney Disease	____ Stroke
____ Asthma	____ Fainting	____ Liver Disease	____ Swelling of Feet or Ankles
____ Back Problems	____ Glaucoma	____ Mitral Valve Prolapse	____ Thyroid Problems
____ Blood Disease	____ Headaches	____ Nervous Problems	____ Tobacco Habit
____ Cancer	____ Heart Murmur	____ Pacemaker	____ Tonsillitis
____ Chemical Dependency	____ Heart Problems _____	____ Psychiatric Care	____ Tuberculosis
____ Chemotherapy	_____	____ Radiation Treatment	____ Ulcer
____ Circulatory Problems	____ Hemophilia	____ Respiratory Disease	____ Venereal Disease

Do you need Antibiotic Premedication prior to dental treatment? YES / NO

List medications you are currently taking: _____

Allergies: ____ Aspirin ____ Penicillin ____ Codeine ____ Local Anesthetic Other: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that the administration of local anesthetic may cause side effects which may include, but are not limited to bruising, hematoma; cardiac stimulation; temporary
or rarely, permanent numbness; or muscle soreness. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event any dispute or claim arising from dental treatment or insurance claims cannot be settled by parties involves, all parties agree to submit said dispute to binding arbitration.

Date: _____ **Signature**: _____

Dr. Notes: _____

_____

FINANCIAL POLICY and INSURANCE GUIDELINES

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care your family deserves.

- If you have dental insurance, we will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you and your children achieve the best oral health possible. Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination. Initial _____

- While we accept all dental insurance plans, we are considered in-network with most PPO dental plans. Delta Dental members: If you receive an insurance check it is to pay your claim at our office. Please bring it in ASAP. Being out of network does not mean you do not receive benefits. We strive to help you make optimal use of your dental insurance and as a courtesy to our patients, we are happy to file your dental insurance claims. Initial _____

- Your insurance policy is an agreement between you and your insurance company; we ask that all patients be directly responsible for all charges. Your estimated co-payment will be due at the time of service, however we cannot guarantee any estimated coverage. You will be expected to pay for services in full if this office is unable to verify your plan information before treatment. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. Initial_____

- If payment for services already rendered has not been paid in full within 6 weeks, either by you or your insurance company, the remaining balance for your treatment is considered due and must be collected from you. Office Delinquent balances over 90 days old will be transferred to a collection agency. The fee accessed for this transfer and administrative expenses is $30.00. Any fees incurred from the collection agency and attorney employed will be passed on to you. Further appointments will not be scheduled until all balances and fees are paid in full. Future appointments will be on a cash only basis. Initial _____

- We accept the following forms of payment: Cash, Check, American Express, Visa and MasterCard. In addition, we offer Care Credit, a patient payment program offering a full range of Deferred Interest and Extended Payment Plans for treatment. Initial _____

- Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office. Your check will be retained by our office until a full cash payment is received. Initial_____

- Separated or divorced parents of minors, who are responsible for one half of the cost of a child's/children's dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. Initial _____

- We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have. Initial _____

I have read and agree to the Financial Policy and Insurance Guidelines.

Signature of Patient or Responsible Party: _____

Date:_____

Lake Country Dental

Ray D. Snider DDS & Associates

Pediatrics, Family Dentistry & Dental Implants

Cancellation Policy

We regret patients must sometimes wait a lengthy time to be seen by one of our dentist. Due to the high demand of appointments and in order to be respectful of the dental needs of all of our patients please be courteous and call our office promptly if you are unable to attend an appointment.
We always have patients on a cancellation list that need care.

If you are unable to keep your scheduled appointment, we require 24 hours notice.

There will be a $35 charge for every appointment missed without proper notification (as mentioned above).

If you miss 2 appointments without proper notification we reserve the right to dismiss the patient from care.

_____ _____

Signature Date