Ricky Lane Dentistry

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____

Social Security #:_____ Birth Date: _____

Phone (Home):_____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____ **Current Employer** _____ **City**_____

For New Patients Only:
Whom may we thank for referring you to our office? _____

Patient Emergency Contact Name & Phone # _____

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
☐ _____

- Do you take antibiotic pre-medication for your dental visits? ☐ Yes ☐ No
  If yes, please explain and list:

- Which Pharmacy do you prefer? _____

- Are you under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:

- Name of Physician: _____Phone:_____

- Do you have any medication or Latex Allergies? If yes, please list:

_____

- List all medications, supplements, and/ or vitamins you are currently taking:

_____

_____

Insurance Information

Primary
Name of Policy Holder: _____

Is the Policy Holder a patient? ☐ Yes ☐ No
Insured's Birth Date: _____ ID #: _____ Group #:_____

Policy Holder's Address:

_____
Street City State Zip Code

Policy Holder's Employer Name:

_____
Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:

_____
Street City State Zip Code

Insurance Plan Customer/ Member Service Number: _____

WE DO REQUEST A COPY OF YOUR DENTAL INSURANCE ID CARD
And your ID

-Dr. Lane is NOT a participating provider with any insurance company. However, as a courtesy to you, we will file all insurance claims to maximize your benefits.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim.

Most importantly, Please keep our office informed of any insurance changes such a policy name, insurance address change, or employment change.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Financial Information

Our financial policy is as follows: Payment is due at the time of services are rendered. Unless, arrangements have been made. Every effort will be made to provide a treatment plan which fits your timetable and budget.

PAYMENT
To assist you we accept: Cash, Credit, Visa, MasterCard, Discover and American Express. We also offer other financing if approved such as Care Credit.

All visits are expected to be paid at the time of service

There will be a $75.00 charge per patient no show fee and/ or cancellation fee. A 24 hour notice is required.

Consent for Services

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

HIPAA ACKNOWLEDGMENT DISCLOSURE

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorizations may be revoked, when the office that receives this authorization receives written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient end, if some may not be subject to federal or state law protecting its confidentiality

Consent for Photographs

Lane Dentistry often takes photos for the purpose of case documentation, laboratory communication, continuing education lecture, PowerPoint slide presentation, in-office communication, and for various dental and/or articles of publication.

I hereby grant permission the use of any and all photography and x-rays of (or minor child / children) to Lane Dentistry for the purpose stated above. I also acknowledge that this is done voluntarily and without compensation.

☐I agree & give consent

Consent for Internet Communications

I grant my permission to Lane Dentistry, (hereafter Dentist) and/or such associates or assistants to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties.

☐I agree & give consent

Privacy Release Information

I authorize the following individuals to request / discuss services / conditions (regarding appointments, care, financials and treatment etc.) on my behalf:

Name: _____Relationship_____Phone_____

Name: _____Relationship_____Phone_____

I have read the information above regarding HIPPA, consent for Photographs, Internet communication and secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian


RICKY LANE
DENTISTRY