LEDERMAN & LEDERMAN DDS

Patient Information

__Mr. __Mrs. __Ms. __Dr. First Name: _____ MI: ___ Last Name: _____

Preferred Name:_____ Birthdate: _____ Age:____ SS#:_____

__Male __Female __Prefer not to say | Preferred Pronouns: _____ | __Single __Married __Widowed

Home Address: _____ City:_____ State: ___ Zip:_____

Preferred Phone Number: (____)_____ EXT._____ Circle: Work Cell Home

Email Address: _____ Employer: _____

Referred by: _____ Other Family members seen by us: _____

DO YOU HAVE DENTAL INSURANCE *Medicare does not cover dental procedures (circle): yes no

PRIMARY DENTAL INSURANCE

Insurance Company Name: _____ Group #_____
ID #_____ Insurance Company Phone # (____)_____

Insurance Company Address: _____

Who is the insured (circle): self spouse mother father

If not self:

Name of Insured: _____ Phone Number of Insured: _____

Employer of Insured: _____ Employer address: _____

SECONDARY DENTAL INSURANCE

Insurance Company Name: _____ Group #_____
ID #_____ Insurance Company Phone # (____)_____

Insurance Company Address: _____

Who is the insured (circle): self spouse mother father

If not self:

Name of Insured: _____ Phone Number of Insured: _____

Employer of Insured: _____ Employer address: _____

_____

Emergency Contact Name: _____ Phone Number: _____

Medical Doctor Name: _____ Phone Number: _____

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Dental History

Dental History

How would you rate your oral health? Poor Okay Good Excellent

How long as it been since your last dental cleaning? _____

Deep Cleaning

Do you have a history of deep cleaning (also referred to as Scaling and Root Planing or SRP)?

Yes No

If so, what is the date of your most recent deep cleaning: _____

Antibiotic Prophylaxis

Do you need to take an antibiotic prior to dental treatment? Yes No

If so, do you need us to fill that prescription for you? Yes No

If so, what pharmacy do you prefer: _____

Homecare

What homecare devices are you using? (circle)

Manual Toothbrush / Electric Toothbrush

Floss / Flosspicks / WaterPik / Interproximal Brushes

TMJ

Do you have a history of (circle): jaw pain jaw joint sounds lockjaw

Anesthesia

Do you have a history of difficulty getting numb: _____

How did you find us?

Referred by a friend: _____

Google

Facebook

Through your insurance

Other: _____

Is there something specific you would like us to address at your first appointment?

_____

_____

_____

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Medical History

Health problems you may have or medication you may be taking could have an important interrelationship with the care that you will be receiving. Your answers are for our records and are confidential.

Do you have or have you had any of the following (circle if yes):

Heart

- Chest Pain
- Shortness of Breath
- Emphysema
- High/Low Blood Pressure
- Blood Pressure
- Heart Valve Problems
- Artificial Heart Valve
- Rheumatic Fever
- Heart Attack/Surgery
- Pacemaker

Blood

- Bruise Easily
- Abnormal Bleeding/Hemophilia
- Anemia

Allergy

- Seasonal
- Sinus Issues
- Skin Rashes
- Taking Allergy Medications

Bone/Joint

- Arthritis
- Back or Neck Pain
- Joint Replacement

Intestinal

- Ulcers
- GERD
- Taking Antacid Medications
- Kidney/Bladder

Neurologic

- Fainting Spells, Seizures, Epilepsy
- Stroke
- Frequent or severe headache
- History of head injury
- Other Neurologic disease

Endocrine

- Hyper/Hypothyroid
- Swollen Glands
- Diabetes
- Family history of Diabetes
- Hepatitis/Jaundice/Liver trouble

Respiratory

- Persistent cough
- History of cigarette smoking
- History of cigar smoking
- History of marijuana smoking
- History of e-cigarette smoking

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Cancer

Cancer or tumor

If yes, what type:

_____

Radiation treatment

If yes, what area of the body:

_____

Chemotherapy

Autoimmune

Sjogren's Syndrome

Lupus

Rheumatoid Arthritis

Women

Pregnant

If so, expected delivery date:

_____

Nursing

Hormone Replacement

Contraceptives/Birth Control Pills

STD

Herpes

Hepatitis

HIV/AIDS

Other STD

Mental Health

History of Drug or Alcohol Abuse

History of Mental Health Problems

Allergies – are you allergic or have you adversely reacted to:

Local anesthetics ("novocaine")

Penicillin or other antibiotics

Sulfa Drugs

Barbiturates/Sedatives

Erythromycin

Tetracycline

Aspirin

Acetaminophen (Tylenol)

Ibuprofen

Naproxen (Aleve)

Codeine or other narcotics

Metals

Latex or rubber dam

Sulfites

Food

If yes, please list:

_____

_____

_____

Medications – please list all medications and dosages

_____

_____

_____

_____

_____

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Medical Release and Agreement

I understand that the information I have given is important to my dental health and it is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that I will be responsible for updating my medical status at every dental visit.

Name: _____

Signature: _____ Date: _____

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my healthcare provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice pf Privacy Practices. I understand that my healthcare provider has the right to change the Notice of Privacy Practices.
Importantly the updated 9/23/13 version of the NOPP reflecting the OMNBUS rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name: _____

Signature: _____ Date: _____

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DENTAL HYGIENE, EXAM, & RADIOGRAPH INFORMATION AND CONSENT FORM

Dental Hygiene Treatment, Oral Exam, Radiographs, Anesthetics, and Medications: We would like our patients to be informed about the various procedures involved in dental treatment and have consent before starting treatment. Dental hygiene procedures are performed to maintain healthy hard and soft tissues in the mouth. Dental hygiene procedures involve hand scaling with dental instruments, scaling with a Cavitron ultrasonic water instrument, polishing with dental paste, flossing, and an exam by a dentist; in any order that your hygienist sees fit.

Dental prophylaxis is typically a biannual dental cleaning of the hard and soft buildup on teeth above and slightly below the gumline.

Scaling & Root Planing is a 2-4 visit dental cleaning to clean all hard and soft buildup from the teeth above and deep below gumline.

Periodontal maintenance is 3 or 4 visit per year dental cleaning to remove hard and soft buildup from above and deep beneath the gumline.

Dental exams are performed biannually to check for abnormalities, disease, or health issues in the hard and soft tissues of the mouth, head, and neck.

Dental radiographs (x-rays) are performed annually to check the hard tissues for abnormalities including cavities, abscesses, or other issues.

Risks of Dental Treatment: Included (but not limited to) are complications resulting from the use of dental instruments, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes to occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth, damage to existing fillings/crowns/bridges/orthodontic appliances; referred pain to ear, neck, and head; vomiting; allergic reactions; and delayed healing. Tissue injury to gums, cheeks, tongue, lips is possible and may necessitate hemostatic materials or sutures. There is potential risk of aspiration of dental materials or instruments which may necessitate chest x-ray and even surgery to remove foreign objects.

Alternative Treatments: The alternative to dental cleaning, exam, and radiographs is no treatment. Risks involved in this choice might include pain, infection, swelling, loss of teeth, and infection of other areas.

Consent: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I understand that any dental hygiene treatment as well as dental radiographs (x-rays) and exams are an attempt to maintain oral health but not a guarantee against bone loss, cavities, or other oral diseases. I also agree that per the policy of Lederman & Lederman, DDS I will be required to have dental radiographs (x-rays) taken annually with a limitation of no more than 2 years without.

Name: _____

Signature: _____ Date: _____

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Financial Policies & Agreement

Appointments Policy

Patients are seen by appointment only. We make every effort to be on time for our patients, and we ask the same courtesy from your family. If you cannot keep an appointment, please notify us immediately, giving a minimum of 48 hours' notice to avoid any missed appointment fees. We realize that unexpected illnesses and emergencies may occur, but we ask for your assistance in this regard.

Missed appointments due to COVID will require a photo of a positive test with date and signature to avoid a late cancellation fee. Missed appointments due to COVID exposure will be charged a late cancellation fee.

Your dental appointments are scheduled carefully. Time, trained personnel, and dental equipment are reserved for each procedure. Your account will be charged a missed appointment fee of $150.00 for missed appointments without proper notification.

Insurance & Patient Co-pay Policy

It is patient responsibility to be fully aware of your insurance benefits and coverage. Your insurance company can provide the most accurate information to you. We suggest that if you have questions about coverage, you call your insurance company directly.

As a courtesy to our patients, we will attempt to verify your plan coverage to the best of our ability 24 hours prior to your scheduled appointment as this ensures us the most up-to-date coverage for your time of service.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage. Estimated Co-Payment's are due at the time service is rendered unless other arrangements have been made in advance. If payment for services already rendered has not been paid in full within 90 days, finance charges will be applied.

Most insurance companies will respond to claims within four to six weeks. Any remaining balance after your insurance has paid is your responsibility. For your convenience we accept checks, cash, American Express, Visa, MasterCard and Discover. All card payments will have a 3% processing fee.

We reserve the right to refer delinquent balances over 90 days to a collection agency of our choice. All referred accounts are marked "Inactive". To have your account "Reactivated", and continue to receive dental treatment in our office, the delinquent balance must be cleared. Only after this total account balance has been paid in full can appointments be made, and your patient status reactivated.

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Financial Agreement

In signing this form I agree to the financial policies of Lederman & Lederman, DDS and authorize payment directly to Lederman & Lederman, DDS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents. I authorize the above dentist and or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions:

Name: _____

Signature: _____ Date: _____