LAWSON FAMILY DENTISTRY

Dr. Chad Lawson, DDS
Dr. Gary Lawson, DDS

WELCOME

We are pleased to welcome you to our office. New patients are always appreciated. Our practice has grown as a result of its excellent relationship with our refering doctors and patients. As our patient feel free, at any time, to express any concerns or ask any questions that you may have to our Dr. Chad Lawson and Dr. Gary Lawson, or to our staff.

PERSONAL INFORMATION

Name: _____
(first) (middle) (last)

Wishes to be called: _____

Address: _____
Street or PO Box City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ SS# _____

❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employer: _____ Occupation: _____

Referred by: _____

In case of an emergency who should we contact? Name: _____

Relationship to patient: _____ Home phone: _____ Work Phone: _____

Previous Dentist: _____ Last date of X-rays: _____ Dentist's phone number: _____

RESPONSIBLE PARTY

Please provide responsible party information below for minor children:

Name: _____

Relationship to patient: _____

Address: _____
Street or PO Box City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ SS# _____

Employer: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insured: _____

Relationship to Patient: _____

Birthdate: _____ SS# _____

Employer: _____

Employer Phone #: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Group #: _____

ID#: _____

Additional Insurance

Name of Insured: _____

Relationship to Patient: _____

Birthdate: _____ SS# _____

Employer: _____

Employer Phone #: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Group #: _____

ID#: _____

(OVER)

AUTHORIZATION AND RELEASE

I authorize Lawson Family Dentistry to release any information including the diagnosis and 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 practicitioners.

I authorize and request my insurance company to pay directly to Lawson Family Dentistry insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. (The amount of coverage paid by your insurance company may be based on your insurance company's own fee schedule for treatment and may be less than actual charges resulting in lower coverage for you. Lower payment is a direct result of the plan selected by your employer.)

I understand that Lawson Family Dentistry cannot waive co-payment and I will be responsible for any co-payment and deductible at the time of any dental appointment for services rendered to me or my dependents.

I understand that if my insurance company is one that sends payment directly to me I will be responsible for payment in full at the time of any dental appointment for services rendered to me or my dependents.

I understand that failure to keep this account current may result in Lawson Family Dentistry being unable to provide dental services except for dental emergencies and/or where there is prepayment for additional services.

I have read the information provided above and agree to all authorizations and terms of payment.

_____ _____

Signature of patient or parent of minor child *Date*

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment:
CASH, PERSONAL CHECK, VISA, MASTERCARD, DISCOVER, CARE CREDIT FINANCING.
ASK US ABOUT OUR NO INTEREST PAYMENT PLAN!

BROKEN APPOINTMENT FEE

We will call 1-2 business days prior to your scheduled appointment to confirm. Please keep us informed of any changes in your address or contact numbers. We ask that you give us a minimum of 24 hour notice when cancelling or rescheduling your appointments. **A $50.00 fee will be charged for broken appointments.**

PRIVACY POLICY

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

_____

Please print name of patient

_____

Signature of patient or parent of minor *Date*

LAWSON FAMILY DENTISTRY

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HEALTH HISTORY

Name: _____ Birth Date: _____ Today's Date: _____

DENTAL HISTORY

1. Reason for today's visit: _____
   _____
2. Date of last dental visit: _____
3. Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No _____
4. Have you had an upsetting experience in a dental office? ❑ Yes ❑ No
   _____
5. Is there anything about having dental treatment that bothers you? ❑ Yes ❑ No
   _____
6. How often do you brush your teeth? _____
7. Do your gums bleed when brushing? ❑ Yes ❑ No
8. What texture of toothbrush do you use? Soft ❑ Medium ❑ Hard ❑
9. How often do you floss your teeth? _____
10. Do your gums bleed when you floss? ❑ Yes ❑ No
11. Do you feel any pain to any of your teeth when you floss or brush? ❑ Yes ❑ No
12. Have you noticed loose teeth? ❑ Yes ❑ No _____
13. Does food get caught between your teeth? ❑ Yes ❑ No _____
14. Do you have or have you ever had any of the following?
    - ❑ Sores or lumps in or near your mouth?
    - ❑ Problems with jaw? (clicking, pain, difficulty opening or closing or chewing)
    - ❑ Head neck or jaw injuries?
    - ❑ Frequent headaches?
    - ❑ Clench or grind teeth while awake or asleep?
15. Have you ever had:
    - ❑ Orthodontic treatment (braces)
    - ❑ Oral surgery
    - ❑ Gum treatment
    - ❑ Bite adjusted
    - ❑ Worn a bite plane or other appliance

MEDICAL HISTORY

1. Date of last physical exam: _____
2. Physician's name: _____
   Address: _____
   Phone No.:_____
3. Are you under the care of a physician?____
4. Have you ever been hospitalized for any surgical operation or serious illness? _____
   If so please explain: _____
   _____
5. Have you had any abnormal bleeding?____
6. Do you bruise easily? _____
7. Do you use: Tobacco ❑ Alcohol ❑ Other Drugs ❑
8. Are you: Pregnant ❑ Trying to get pregnant ❑ Taking birth control pills ❑ Nursing ❑

Are you taking any medications, including non-prescription medicines?
Please list medications below:

_____
_____
_____
_____
_____
_____
_____
_____
_____

(OVER)

HEALTH HISTORY

Do you have or have you had any of the following:

	YES	NO		YES	NO		YES	NO
Aids or HIV Infection	❑	❑	Heart disease	❑	❑	Lung problems	❑	❑
Anemia	❑	❑	Heart surgery	❑	❑	Pacemaker	❑	❑
Arthritis	❑	❑	Hepatitis A	❑	❑	Rheumatic fever	❑	❑
Cancer	❑	❑	Hepatitis B	❑	❑	Rheumatic heart disease	❑	❑
Cough (persistent)	❑	❑	Hepatitis C	❑	❑	Scarlet fever	❑	❑
Cough (produces blood)	❑	❑	High blood pressure	❑	❑	STD	❑	❑
Diabetes	❑	❑	Jaundice	❑	❑	Sinus trouble	❑	❑
Epilepsy	❑	❑	Joint replacement	❑	❑	Stomach ulcer	❑	❑
Fainting spells	❑	❑	Kidney trouble	❑	❑	Stroke	❑	❑
Glaucoma	❑	❑	Low blood pressure	❑	❑	Thyroid trouble	❑	❑

Are you allergic to or have had reactions to:	YES	NO
1. Local anesthesia like Carbocaine or Septocaine?	❑	❑
2. Penicillin or other antibiotics?	❑	❑
3. Sulfa Drugs?	❑	❑
4. Barbiturates, sedatives, sleeping pills?	❑	❑
5. Metals?	❑	❑
6. Latex?	❑	❑

Do you have or have you had any allergic reactions to any medications not listed above? Please list:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to provide precise information and inform the dental office of any changes in medical status.

_____

Signature of patient or parent of minor *Date*

Do you have any medical conditions not listed above? Please list:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

LAWSON FAMILY DENTISTRY

Dr. Chad Lawson, DDS  Dr. Gary Lawson, DDS

FINANCIAL POLICY

The following financial policies have been put in place to ensure that we provide high quality dental care to each of our patients. We value our relationship with our patients and will be happy to assist you with any questions or concerns you may have regarding our policies.

- **Patients with dental insurance** — we will file to your insurance as a courtesy to you. Please understand that only you have a contract with your insurance company. The percentage paid for your dental treatment is determined by the plan chosen by you or your employer. We have no control over how your insurance pays its claims or the amount it pays. Although we are able to estimate what your insurance will pay, at no time do we guarantee payment from them. **You will be responsible for your deductible and co-pay at the time of service, as well as any balance that may remain after your insurance has paid.**
- Our office serves as In-Network Participating Providers with MetLife, Delta Dental, CIGNA, and Guardian. However, for major services (crown and bridge and complete or partial dentures) an additional lab fee will be charged to cover the lab expenses. You are responsible for this cost.
- If we have knowledge that your insurance company sends payment directly to you rather than to our office, you will be required to pay in full at the time of service.
- If your insurance company has not paid your account in full within 90 days, you will be responsible for the balance. It is your responsibility to negotiate disputed claims with your insurance company.
- **If you do not have dental insurance, payment is due in full at the time of service.**
- We accept cash, check or money order, Visa, MasterCard, Discover, and CareCredit®. Applications for the extended payment plan with CareCredit® are available at our front office.
- **A $25 fee will be applied for any returned or unpaid checks.** You may be placed on a cash-only basis following any returned check.
- **A $50 fee will be applied for broken or missed appointments without a 48 hour notice. After 3 broken appointments, you will be dismissed from our practice.**

  _____ (Initial)
- In the event that your account is turned over to a collection agency, you will be responsible for all associated fees.

Please feel free to ask any questions regarding our policies.

Please sign below stating that you understand and accept our policy.

_____ _____

Patient of Parental Guardian Signature *Date*