Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)

Gender: ____________ Marital Status: ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ (Cell): __________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________________

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

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

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________________
- Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________________ Date: ______________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ______________

Name of person or office referring you to our practice: ______________________________

Employment Information

Please list employment information for the person who is the primary insurance policy holder.

Employer Name: ______________________________ Occupation: ______________________________

Address: ____ , ____________________
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: __________________ Group #: __________________

Name of Insurance Company: ______________________________ Phone Number: ________________

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Secondary

Name of Insured: ______________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: __________________ Group #: __________________

Name of Insurance Company: ______________________________ Phone Number: ________________

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Financial Policy & Agreement

Our office wants all of our patients to be able to comfortably afford their dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best fits their needs.

_____ **Insurance:** Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your treatment cost. Since this is the case, you will be asked to pay your deductible and your co-payment for the charges on the day service is rendered. We will estimate as closely as possible to your coverage, but we can make no guarantee of estimated coverage.

_____ Since your insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges is your own. If after 60 days the insurance company has not paid on your claim, you will be responsible for the total balance.

Payment Options: Please initial next to the agreed upon payment option.

1. Cash, check or credit card: We accept Visa, Mastercard, Discover and Amex. _____
2. 1/2 in advanced and 1/2 at the time of service. _____
3. Paid in full at the time of service. _____
4. Care Credit (3rd party financing): an interest free financing plan that allows you to break down payments monthly for up to 12 months. _____

We also offer an In-House dental savings plan if you do not have insurance. If you are interested in additional savings please ask one of our team members.

_____ **Cancellation/Missed Appointments:** Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a fee for all cancelled or missed appointments without 48 hour notice. If an appointment is missed or cancelled with less than 24hours notice, a **$25** cancellation fee and a **$100** facility fee will be incurred.

I understand and agree to this Financial Policy and Agreement.

______________________________________ Date: ____________ Relationship to Patient: ______
Signature of patient, parent or guardian

______________________________________ Date: ____________ Relationship to Patient: ______
Signature of guarantor of payment/responsible party

Chart #: __________
FOR OFFICE USE ONLY

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

E-Mail Address: ______________________________________

Consent for Use and Disclosure of Health Information

I grant my permission to S. Keith Mahan, DDS, PA to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured dental software for S. Keith Mahan, DDS, PA. S. Keith Mahan, DDS, PA is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand S. Keith Mahan, DDS, PA is not liable for any harm related to the theft of my ID, my disclosure of my ID, or my authorization to allow another person or entity to access and use the S. Keith Mahan, DDS, PA web site with my ID. I also agree to immediately notify S. Keith Mahan, DDS, PA of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand 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 understand S. Keith Mahan, DDS, PA will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that S. Keith Mahan, DDS, PA has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand S. Keith Mahan, DDS, PA will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the dental software on my behalf. I understand S. Keith Mahan, DDS, PA CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the secured dental software for S. Keith Mahan, DDS, PA, and grant S. Keith Mahan, DDS, PA permission to securely upload my patient information to the secured dental software.

______________________________________ Date: _____________ Relationship to Patient: ___________________
Signature of patient, parent or guardian

Medication List

Please inform our office if you have had any medication changes since your last visit. Thank you!

Medication Name	Dose (mg)	How often?	Comments

Your Smile Survey

Answer these few questions as honestly as you can. They'll help you find out how Lumineers can give you a beautiful, white smile- the one you've always wanted- in just two easy visits!

1. Do you like the appearance of your smile?
2. Do you like the appearance of your teeth?
3. Do you like the color of your teeth?
4. Do you have spaces between your teeth that you don't like?
5. Do you like the size and shape of your teeth?
6. Are there old fillings or dental work you don't like looking at?
7. What would you like to change the most about the appearance of your teeth?

____
____
____

Lumineers

Beautiful smile. Beautiful you.