Patient Registration

Patient Name			Today's Date
Gender: □ M □ F	Birth date	Please check one: □ Single □ Married □ Separated □ Widow	
Home Address			
City	State	Zip	Email Address
Cell Phone Number	Home Phone Number	Work Phone Number	
Are you a full time student? □ YES □ NO	*If patient is a minor, we need Mother's birth date and Father's birth date*		
Your Employer	**Person responsible for account** (Parent if minor)	Cell Phone Number (responsible party if minor)	
Your Driver license number (responsible party if minor)	Your Social Security Number (responsible party if minor)		
How did you hear about our office?	**EMERGENCY CONTACT INFORMATION** Name, address, telephone number , relationship to contact		
Reason for this visit			

NOTE: We respect your time and appreciate when you respect the time reserved for you. **A $35.00 cancellation fee will be charged for appointments canceled with less than 48 hours notice and missed appointments.**

Dental Insurance Information

DENTAL INSURANCE INFORMATION (Primary Carrier)		
Insured's name	Birth date	ID # or SS#
Insured's employer		
Insurance Co.		Group #
Insurance Co. Address		
Phone No.		

Financial Policy

Thank you for choosing Lifetime Dental, Inc. as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and CareCredit. Financing is available upon request and approval.

☐ **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimates is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company' s arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. In the event we a participating provider with your insurance company, this form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express, Discover, or CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Signature_____ Date_____

(Patient or Guardian)

Treatment Consent

I, _____, authorize Lifetime Dental, Inc. Doctors and designated staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor (s) in order to make a thorough diagnosis of my dental needs. I authorize the Doctor(s) and designated staff to perform all forms of treatment, medication, and therapy that may be indicated in connection with my case or my dependent's case with my consent. I understand that the use of anesthetic agents embodies a certain risk. I authorize the Doctor(s) may choose to employ such assistance as they deem fit.

Release of Information and Message Permission

I, _____, authorize Lifetime Dental, Inc. to release any of the following personal information regarding my diagnosis, proposed, pending and/or completed treatment, billing, insurance, records to the following individuals:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] No information is to be release to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____.
Please call: [ ] home phone_____ [ ] cell phone _____ or
[ ] work phone_____.

If unable to reach me: [ ] you may leave a detailed message, [ ] please leave me a message asking for a return call OR

[ ] e-mail me at_____ or [ ] Text me at _____.

Email

I grant permission to Lifetime Dental, Inc. to contact me via email. Correspondence may include appointment confirmations, newsletters, special announcements, and offers. NOTE: Privacy is important to us. We will not sell, rent, or give your email address to anyone. At any point, you may unsubscribe from email by clicking on the "unsubscribe" link at the bottom of any email.

Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Charles W. Reinertsen, D.M.D. • Michelle Buechele, D.M.D.
215 E. Burleigh Blvd., Tavares, FL 32778 • Tel (352) 253.6400 Fax (352) 253.6401
www.LifeTimeDental.us

MEDICAL HISTORY

Patient Name_____ Birthdate_____ Today's Date_____

Who is your family physician/internist? _____

FAMILY HISTORY If any blood relative has suffered from the following conditions, please indicate.

Condition	Family Member(s)	Age of Onset
Alzheimer's/ Dementia		
Cancer (please include type)		
Carotid Artery Surgery		
Diabetes		
Heart Attack		
Rheumatoid Arthritis		
Stent or Bypass Surgery		
Stroke		
Other Autoimmune Disease (please explain)		

YOUR PRESENT AND PAST HEALTH CONDITIONS

Have you ever had, or do you have:

☐ Auto-Immune Disease ☐ Dementia ☐ Heart Attack ☐ Heart Blockage ☐ Stroke

Direct Causes of Disease:

☐ High Blood Pressure ☐ High Cholesterol

Major Root Causes of Disease:

☐ Diabetes ☐ Periodontal Disease ☐ Sleep Apnea ☐ Smoking

Other Diseases Associated with Vascular Disease:

☐ Anxiety ☐ History of Preeclampsia ☐ Polycystic Ovaries
☐ Breast Cancer Treatment ☐ Kidney Disease ☐ Psoriasis
☐ Erectile Dysfunction ☐ Lupus ☐ Restless Leg Syndrome
☐ Gout ☐ Migraine Headache ☐ Retinopathy
☐ High Adrenaline Career (i.e.: Policeman, Fireman, etc.) ☐ Rheumatoid Arthritis

Have you been told you need to take antibiotics before dental work? ☐ Yes ☐ No

What surgeries have you had? If so, please include the year. (Joint replacement, heart valve replacement, etc.)

_____

_____

Have you been told you have hypoglycemia, hyperglycemia, borderline blood sugars or pre-diabetes? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what kind? _____

Do you get frequent sinus infections? ☐ Yes ☐ No

Do you have any allergies? (Check all that apply).

☐ Codeine ☐ Gluten ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ None
☐ Other: _____

Have you ever had pneumonia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Have you been told that you stop breathing or choke/gasp in your sleep? ☐ Yes ☐ No
Do you feel rested upon waking? ☐ Yes ☐ No
Do you doze off during the day? ☐ Yes ☐ No

How many alcoholic drinks do you consume per week? _____ (*One drink= 1 beer or 5 oz wine or 1.5 oz hard liquor)*

Do you, or have you ever used tobacco products? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chewing Tobacco
If yes, _____ pack(s)/day Number of years _____ Year quit (if applicable) _____

Are you pregnant or nursing? ☐ Yes ☐ No

YOUR MEDICATIONS & SUPPLEMENTS Please list any medications and supplements that you currently take.

_____

_____

_____

Do you take any blood thinners, prescribed or OTC?
☐ Aspirin ☐ Coumadin ☐ Garlic ☐ Fish Oil ☐ Plavix ☐ Warfarin ☐ None
☐ Other: _____

Do you take any medications for osteoporosis?
☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosomax ☐ Reclast ☐ Zometa ☐ None
☐ Other:_____

Is there anything we need to know about your health that is not listed above? ☐ Yes ☐ No
If so, please share_____

DENTAL HISTORY

Please check any of the following problems that apply to you.
☐ Bad breath
☐ Bleeding, swollen or irritated gums
☐ Broken teeth or fillings
☐ Grinding or clenching teeth
☐ Headaches, earaches or neck pain
☐ Jaw joint pain
☐ Loose, tipped or shifting teeth
☐ Sensitivity **Where?** UR UL LR LL

Do you have or have you had any of the following?
☐ Braces ☐ Periodontal (gum) treatments
☐ Dentures ☐ Partial Dentures

Please share the following dates:
Your last cleaning _____
Your last oral cancer screening _____
Your last complete set of x-rays _____

Name of previous dentist: _____

_____
City, State Telephone Number

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your future smile and dental health?

_____

_____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐ Yes ☐ No

If I could change my smile, I would:
☐ Make them whiter ☐ Make them straighter
☐ Close spaces ☐ Repair chipped teeth
☐ Replace old crowns that don't match
☐ Replace metal fillings with tooth colored fillings
☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

_____

_____

_____
Patient Signature Date

_____
Provider Signature Date