Sleep Dentistry Defined

Heath A. Lampee, DMD
DrLampee.com

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
(Please print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please specify)

_____

_____

_____

You may refuse to sign this acknowledgment

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Missed Appointment Policy

We require two business days' notice to reschedule an appointment. Our business days are Monday–Thursday.

- There is no fee for your first missed appointment. We understand that life happens.
- There is a $50 fee for your second missed appointment.
- There is a $100 fee for your third missed appointment.
- Additional missed appointments will result in us not being able to see you as a patient.
- If a sedation appointment or appointment lasting two or more hours is missed or rescheduled with less than two business days' notice, 10% of your appointment cost is non-refundable.

(Signature of Patient or Responsible Party)

(Date)

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Policy Acknowledgment

We are committed to providing you with the best possible dental care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policies.

PAYMENT OPTIONS

- **5% savings** on **uninsured** treatment, paid-in-full at the time of treatment. **5% savings** for seniors 60+
- We accept the following major credit/debit cards: **VISA, MC, DISCOVER** and **AMERICAN EXPRESS**.
- For those who desire a payment plan, we are partnered with **Care Credit**. This payment plan is based on your approved credit. There are no application fees. These arrangements must be made prior to treatment.

INSURANCE

Payment of your deductible and the estimated portion your insurance does not cover, are expected at the time of treatment. We will provide insurance billing as a service to you. However, if there is no payment from your insurance company to our office within 45 days, you are responsible for the balance in full at that time. Any balances unpaid after 30 days will be subject to interest equal to 1.5% per month. **Balances over 90 days will be assigned to a collection agency and will incur a $50.00 collection fee. Any checks returned to our office for non-sufficient funds will be subject to a fee of $25.00.**

USUAL AND CUSTOMARY RATES

We charge what is usual and customary for our area. Please be aware that some of the services we provide **may not be covered services by your dental plan**. You are responsible for payment regardless of your insurance company's exclusions and fee schedules. Your insurance policy is a contract between you and that insurance company. We are not able to negotiate with your insurance company on your behalf.

MINOR PATIENTS

If a minor is not accompanied by their parents/guardian, arrangements for payment need to be made prior to the appointment.

I have read the Policy Acknowledgment and understand that as a patient, or legal guardian of a minor patient, I agree to pay all services rendered in accordance with the terms and conditions set forth in the financial policy of this office as stated above.

_____ _____

(Signature of Patient or Responsible Party) (Date)

The above information is true to the best of my knowledge. I understand that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1.5% will be applied, per month, to accounts over 30 days or more. I authorize Sleep Dentistry Defined to submit charges to cover balances over 30 days or more.

CREDIT CARD ON FILE

VISA / MC / DIS /AMEX / CareCredit # _____ - _____ - _____ - _____ Exp _____ / _____

_____ _____

(Signature of Patient or Responsible Party) (Date)

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Patient Information

Name _____ Preferred name _____

Parent/Guardian (if Minor child) _____

Address _____ Unit _____

City _____ State _____ Zip _____

Phones (home) _____ (work) _____ (cell) _____

Email _____ Date of birth (mm/dd/yr) _____

Drivers License or State ID: _____ EXP: _____

Social Security: _____ Who may we thank for referring you? _____

Why are you here today? _____

INSURANCE INFORMATION

Insured Name _____ Relationship to Patient: Parent / Guardian / Spouse / Other

Employer _____ Phone _____

SS# or Alternate ID#: _____ Date of birth (mm/dd/yr) _____

Dental Insurance Company _____ Group# _____

Phone _____ Website _____

Claims mailing address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Phones(hm) _____ (cell) _____

Relationship to Patient: Parent / Guardian / Spouse / Other _____

Are you satisfied with the appearance of your teeth? Y / N

Would you like a whiter smile? Y / N

Are you interested in Sleep Dentistry? Y / N

Would you like straighter teeth? Y / N

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Patient Medical History

Name _____ Date _____

Physician's name _____ Phone _____

Are you under medical treatment now? Y / N If yes what for _____
Are you or have you ever been hospitalized for any surgical procedure or serious illness? Y / N
Are you taking any medication(s) including non-prescription? Y / N If yes, what medication(s) or supplements are you taking? _____
Do you use tobacco? Y / N Do you use alcohol? Y / N
Do you use recreational drugs? Y / N If yes, which types? _____

Are you allergic to or have you had any reaction to the following:

Topical Anesthetics	Y / N	Ibuprofen (Advil)	Y / N
Local Anesthetics	Y / N	Prescription Pain Medications	Y / N
Latex	Y / N	Sulfa Drugs	Y / N
Aspirin	Y / N	Penicillin	Y / N
Tylenol	Y / N	Sedatives	Y / N

Other: _____

Do you or have you had any of the following:

Y / N	High BP	Y / N	HIV	Y / N	Weight Loss
Y / N	Low BP	Y / N	Liver Disease	Y / N	Frequently Tired
Y / N	Blood Thinners	Y / N	Epilepsy	Y / N	Kidney Disease
Y / N	Heart Attack	Y / N	Convulsions	Y / N	Rheumatic Fever
Y / N	Murmur	Y / N	Glaucoma	Y / N	Cold Sores
Y / N	Heart Disease	Y / N	Leukemia	Y / N	Cancer: _____
Y / N	Pacemaker	Y / N	Diabetes Type I or II	Y / N	Autoimmune Disorder: _____
Y / N	Angina	Y / N	Anemia		
Y / N	Stroke	Y / N	AIDS	Y / N	Mental Illness: _____
Y / N	Chest Pains	Y / N	Thyroid		
Y / N	Asthma	Y / N	Ulcers	Other: _____	
Y / N	Radiation	Y / N	Joint Replacement		
Y / N	Tuberculosis	Y / N	Edema	**Women Only:**	
Y / N	Emphysema	Y / N	Arthritis	Are you pregnant? Y / N	
Y / N	Fainting	Y / N	Hepatitis Type A / B / C	Are you nursing? Y / N	
Y / N	COPD	Y / N	Hay Fever	Birth Control Pills? Y / N	

Patient Consent Agreement:
I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information may be dangerous to my health. I hereby authorize and request the performance of dental services for myself and/or for: _____.
I authorize and give consent to perform dental services agreed upon between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated.

Patient or Guardian Signature _____ **Date** _____
Reviewed and updated: _____ Date _____
Reviewed and updated: _____ Date _____
Reviewed and updated: _____ Date _____
Reviewed and updated: _____ Date _____
Reviewed and updated: _____ Date _____
Reviewed and updated: _____ Date _____