Interlakes
FAMILY DENTAL

Please sign below after you read and understand our programs and policies.

Referrals

For every new patient, you refer to Interlakes Family Dental Center you will receive $25 account credit to be used in our office. The credit will be applied to your account when the new patient has completed this form * with your name written in the "Who may we thank for inviting you?" section. *

Who may we thank for inviting you?

- o Current Patient:
- o Through my dental insurance company
- o On the internet
  - o Google
  - o Yahoo
  - o Bing
  - o Yelp
  - o Facebook
  - o Healthprofs.com
  - o Healthgrades.com
  - o Other (please specify): _____

Financial Policy

Compensation for services is due when treatment is performed. Payment options include: cash, check, credit card, or third party financing through Care Credit or Lending Club Payment Solutions. We want to help you achieve your goals, so if you would like to discuss payment options please speak with Lisa, our Treatment Coordinator.

Missed Opportunity Policy

We are dedicated to giving you the best care possible. If you are unable to keep your appointment, please give us at least 24 hours notice so someone else may have the opportunity to use the time we have reserved for you. If you cancel last minute, or do not come to a scheduled appointment due to a non-emergency, we will charge you $50 for a missed opportunity with the doctor and/or $30 for a missed opportunity with your dental hygienist. Thank you in advance for your cooperation in ensuring a smooth-running schedule.

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt Notice of Privacy Practices

Consent to Share Information

I, (print name) _____, give permission to share information regarding my treatment and/or finances to (check all that apply):

- o Parent Name: _____
- o Spouse Name: _____
- o Guardian Name: _____
- o Other: _____

I also give permission for messages to be left on my home, work, or personal voicemail for confirmation of appointments or to communicate insurance or account information.

_____ _____

Patient Signature Date

HIPAA Privacy Notice

I, (print name) _____, have read and understand the notice of privacy practices at Interlakes Family Dental Center and acknowledge that I may request a copy of the document at any time.

_____ _____

Patient Signature Date

You may refuse to sign this acknowledgment

Office Use Only

- o Acknowledgement could not be obtained due to:
- o Refusal to sign
- o Communication barriers prohibited information consent
- o An emergency situation prevented our ability to obtain acknowledgement
- o Other: _____

Office Team Member: _____ Date: _____

TIME 11:07 AM

Interlakes
FAMILY DENTAL

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Who referred you? _____

Current PCP? _____

Personal Motivator? _____

Former Dental Office? _____

AM or PM appts? _____

Dental Fears? _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Interlakes
FAMILY DENTAL

60 Whittier Highway
Suite 1
Moultonborough, NH 03254
Phone: 603-253-4363
Fax: 603-253-4148

Date:

Dear Dr.

Please forward all records for _____ to:

Interlakes Family Dental Center
60 Whittier Highway
Suite 1
Moultonborough, NH 03254

This request also applies to the following patient (s):

_____ D/O/B _____

_____ D/O/B _____

_____ D/O/B _____

Please consider this signed form as an official release.
Your prompt attention to this request is appreciated.

Signature of patient or guardian: _____

Printed name of patient or guardian: _____

Time 9:56 AM | Interlakes Family Dental Center | Date 7/26/2016

Customized Medical History (Revised)

Patient Name: Birth Date: Date Created:

Physician, Medications and Allergies

Do you have a primary care physician? Please list location and phone number	○ Yes ○ No	If yes
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you been hospitalized or had a major operation? If so please list surgery and date	○ Yes ○ No	If yes
Have you had a joint replacement? If so please list doctor name, location, and date of surgery	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medication, supplements, vitamins, or drugs? If so, what do you take?	○ Yes ○ No	If yes
Do you take Coumadin or other blood thinners?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you drink alcohol? If so, How much?	○ Yes ○ No	If yes
Do you use tobacco? If so, how long and how much?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Are you allergic to any of the following?

☐ Acrylic	☐ Gluten	☐ Local Anesthetics	☐ Penicillin
☐ Aspirin	☐ Iodine	☐ Metal	☐ Sulfa Drugs
☐ Latex			

Do you have any other allergies? If so please list	○ Yes ○ No	If yes

Past Dental Experience

Have you ever had a difficult dental experience?	○ Yes ○ No	If yes
Have you ever had orthodontic treatment? If so, please list doctor, phone number, and date	○ Yes ○ No	If yes
Have you ever been diagnosed with periodontal disease? If so, please list doctor's name, phone	○ Yes ○ No	If yes

Oral Health

Do you have, or have you had, any of the following?

Difficulty Swallowing	○ Yes ○ No
Excessive Thirst	○ Yes ○ No
Bad Breath	○ Yes ○ No
Dry Mouth	○ Yes ○ No
Neck or Jaw Pain/Discomfort	○ Yes ○ No
Clenching or Grinding your teeth	○ Yes ○ No

Is your water fluoridated?	○ Yes ○ No	
Do you wear Retainers or a Night Guard? Please	○ Yes ○ No	If yes
Do you wear dentures or partials?	○ Yes ○ No	If yes
Do you think you have a healthy mouth?	○ Yes ○ No	
Would you change anything about your smile? If so, what would you change?	○ Yes ○ No	If yes

Women

Women: Are you...

☐ Pregnant/Trying to Get Pregnant ☐ Nursing ☐ Taking oral contraceptives?

Have you ever had pregnancy complications?	○ Yes ○ No	If yes

Family History

Has anyone in your immediate family been diagnosed with any of the following? If so, who?	○ Yes ○ No		
Alzheimer's Disease	○ Yes ○ No	If yes	
Cancer	○ Yes ○ No	If yes	
Diabetes	○ Yes ○ No	If yes	
Heart Attack/Failure	○ Yes ○ No	If yes	
Periodontal Disease	○ Yes ○ No	If yes	
Thyroid Problems/Disease	○ Yes ○ No	If yes	

Diseases

Do you have, or have you had, any of the following?

Acid Reflux/Gerd	○ Yes ○ No	AIDS/HIV Positive	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Anaphylaxis	○ Yes ○ No
Anemia	○ Yes ○ No	Angina/Chest Pain	○ Yes ○ No	Anxiety	○ Yes ○ No	Arrhythmia	○ Yes ○ No
Arthritis	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Asthma	○ Yes ○ No
Autism Spectrum Disorder	○ Yes ○ No	Autoimmune Disorder	○ Yes ○ No	Blood Disease	○ Yes ○ No	Blood Thinners	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Breathing problems	○ Yes ○ No	Bruise easily	○ Yes ○ No	Cancer	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Congenital Heart Disease	○ Yes ○ No	Convulsions	○ Yes ○ No
COPD	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Diabetes (Type I)	○ Yes ○ No	Diabetes (Type II)	○ Yes ○ No
Difficulty Sleeping	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Easily Winded	○ Yes ○ No	Emphysema	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Frequent Diarrhea	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Glaucoma	○ Yes ○ No	Gout	○ Yes ○ No
Hay Fever/Seasonal	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No	Hemophilia	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No
Herpes	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Inflammatory Disease	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Irritable Bowel Syndrome	○ Yes ○ No
Jaundice	○ Yes ○ No	Kidney Disease	○ Yes ○ No	Kidney Stones	○ Yes ○ No	Leukemia	○ Yes ○ No
Liver Disease	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Lung Disease	○ Yes ○ No	Lyme Disease	○ Yes ○ No
Migraines	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Parkinson's Disease	○ Yes ○ No	Pre Eclampsia	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Recent Extreme Weight Loss	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Rheumatism	○ Yes ○ No
Scarlet Fever	○ Yes ○ No	Shingles	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Spina Bifida	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Thyriod Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Ulcers	○ Yes ○ No	Vascular Dysfunction	○ Yes ○ No	Venereal Disease	○ Yes ○ No		

Have you ever had any serious illness not listed	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Have you ever taken Phen-Fen or Redux?	○ Yes ○ No	If yes	

Comments - Please list any additional doctors not listed above

Emergency Contact name and phone number

Signature

Signature of Patient, Parent or Guardian:

X_____ Date:_____