Daniel H DeTolla D.D.S., M.D.
Dave D Pak D.D.S., M.D.
Diplomates, American Board
of Oral and Maxillofacial Surgery

Financial Policy

Thank you for choosing Lakes Region Dental Implant & Oral Surgery Center, P.A. We are committed to providing the best care for our patients and making your experience a positive one in every way we can.

Payment Policy: We ask that you read through the financial policy and sign at the bottom of this page prior to any consultation or treatment. Full payment is due at the time of service unless prior arrangements have been made with our office. We accept CASH, CHECKS, or CREDIT CARDS. We can also give you information about Care Credit, a patient financial plan that we offer.

Regarding Insurance: We are participating providers with a number of dental and medical insurance plans. We also accept assignment from plans where we are not participating providers. Before treatment is rendered, we will contact your insurance companies to verify eligibility and benefits. Our experience is that this information is not always accurate or current. You are encouraged to call your insurance company to obtain benefit information as well. If it is critical that you know precisely the coverage you have for the specific treatment recommended, we will be happy to submit a written pre-treatment coverage determination. This may take up to six weeks. We will submit to all insurance plans as a courtesy to you. Your insurance policy is a contract between you and the insurance company; we are not a party to that contract. Regardless of benefits or coverage, *you are responsible* for any amount that is *not covered* and *not paid* by your insurance. You are also responsible for the entire treatment costs in the event that you are not eligible for insurance coverage on the day service is rendered, regardless of the private, state or federal insurance program that you participate with.

Insurance Referrals: It is your responsibility to obtain a referral from your Primary Care Physician before seeking treatment from us, if your plan requires it. If a claim is denied due to a lack of referral you will be responsible for the charges.

Interest: Interest at the rate of 1.5% per month or 18% per annum will be charged on balances unpaid after 30 days.

Missed Appointments: We do expect notice of cancellation 24 hours prior to your appointment, as a courtesy to the Doctor's, Staff and Other patients.

Minor Patients: Parents or guardians are responsible for all charges for minor children.

Please let us know if you have any questions regarding our Financial Policy.

I have read the Financial Policy; I understand and agree to this Financial Policy.

X______________________________ X______________________________

Signature of person financially responsible Please print full name

Today's Date: ________________

Lakes Region
Dental Implant & Oral Surgery Center, P.A.

Daniel H De Tolla D.D.S., M.D.
Dave C Pak D.D.S., M.D.
[illegible] American Board [illegible] Surgery

CONFIDENTIAL PATIENT INFORMATION

Patient: ______________________ **Date of Birth:** ________ **Age:** ____ **Male OR Female** **Marital Status:** **M S D W**
Last First Middle (Circle)

Mailing Address: ____
Street/P.O. box/ Apt # City/Town State Zip code

Home Phone: __________ **Cell Phone:** __________ **Soc. Sec. #:** __________ **E-mail:** __________

Referred By: ______________ **Phone:** ______________

Employer: ______________ **Occupation:** ______________ **Phone:** ______________

Dentist: ______________ **Phone:** __________ **Physician:** ______________ **Phone:** __________

IF STUDENT OR MINOR, PLEASE COMPLETE INFORMATION BELOW

School: ______________ **Address:** ______________________ **Grade:** ______

Father's Name: ______________ **Soc. Sec. Number:** __________ **D.O.B:** ______ **Employer:** ______________

Mother's Name: ______________ **Soc. Sec. Number:** __________ **D.O.B.** ______ **Employer:** ______________

Mailing Address (If different, specify mother/father): ______________________________

Home Phone (If different, specify mother/father): ______________________________

Please Complete All Insurance Information – Please note, Social Security numbers are necessary when it is the subscriber ID #

Dental Insurance: ______________ **Subscriber ID #:** ______________ **Group #:** __________

Name of Policy Holder: ______________________ **D.O.B.:** ______ **Relationship:** __________

Employer: ______________ **Business Phone:** __________ **Address:** ______________

Medical Insurance: ______________ **Subscriber ID #:** ______________ **Group #:** __________

Name of Policy Holder: ______________________ **D.O.B.:** ______ **Relationship:** __________

Employer: ______________ **Business Phone:** __________ **Address:** ______________

Other Insurance: ______________ **Subscriber ID #:** ______________ **Group #:** __________

Name of Policy Holder: ______________________ **D.O.B.:** ______ **Relationship:** __________

Employer: ______________ **Business Phone:** __________ **Address:** ______________

Please sign below, thank you.

Patients or authorized person's signature (I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct) I authorize payment of insurance benefits to Dr. Daniel H. De Tolla and Dr. Dave C. Pak or Lakes Region Dental Implant and Oral Surgery Center, P.A.

Payment is expected upon completion of service. Balances unpaid after 30 days are subject to a late payment of 1.5% per month or 18% per annum

____
Patient/Parent/Authorized Person *Date*

Lakes Region Dental Implant and Oral Surgery Center
Medical History

Patient's Name ______________________ **Date of Birth** __________ **Height** ______ **Weight** ________

Answer all questions by circling Yes (Y) or No (N). Additional comments and information can be listed on the back of the form. All responses are kept confidential.

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam ______________
4. Are you now under a physician's care for a particular problem? .... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: .... Y N

____

____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Sleep Apnea or Snoring? .... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
   - T. Osteopenia, Osteoporosis or other bone disease?. Y N
   - W. Are you taking or have you ever taken a bisphosphonate ("bone medicine") for treatment of a bone disorder? .... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (Blood Thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? .... Y N
   - E. Antidepressants, Tranquilizers .... Y N
   - F. Insulin or Oral Anti-Diabetic drugs? .... Y N
   - G. Digitalis, Inderal, Nitroglycerin or other heart drug? .... Y N
   - H. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: ______

     ____

     ____
   - I. Have you taken a steroid medication (prednisone, cortisone) in the last year? .... Y N
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, Lidocaine, etc.)? ...... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain medications? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please, list .... Y N

     ____

     ____
9. Do you smoke or chew Tobacco? .... Y N
   How much per day? ______________
10. Do you have a past history of Alcohol or Chemical Dependency or Emotional Disorder? .... Y N
11. Have you had any serious problems associated with any previous dental treatment? .... Y N
12. Have you or an immediate family member had any Problem associated with deep sedation or general anesthesia? .... Y N
13. Do you have any other disease, condition or Problem not listed above that you think the doctor should know about? .... Y N
14. Do you wish to talk to the doctor privately about anything? .... Y N
15. **FOR WOMEN ONLY**
   - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y N
   - B. Are you nursing? .... Y N
   - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date	Signature of Person Completing Health History	Doctor's Initials

Medical Update: I have read my Health History dated ______________ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I have received a copy of this office's Notice of Privacy Practices. They are attached to the clipboard. Please sign and print below.

____ **Date:** _________

Signature

____

Please print name of person signing, Patient or Parent (if minor)

If you would like to allow us to discuss your treatment with anyone please fill out the following information.

Name: ________________________ **Relation:** _____________

Name: ________________________ **Relation:** _____________

You may refuse to sign this acknowledgement

FOR OFFICE USE ONLY

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

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgment**
- ☐ **Other(Please Specify):** ____