STONEGATE DENTISTRY
JOHN F. LANN, DDS

Adult Patient Health / Dental History Form

Patient's Name (Last, First, Initial)		Preferred Name	Today's Date
Social Security #	Driver License #	Date of Birth	Sex M or F
Address (Address, City, State, Zip Code)			
Phone # (Cell, Home, Work)		Email	
Occupation		Employer	

Referral Information

Whom may we thank for referring you to our practice? _____

Health History

Date of last dental visit: _____ Reason for today's visit: _____

Have you ever had any of the following? (please check all that apply)

- ☐ AIDS
- ☐ Allergies: *(please circle)*
  - Latex
  - Codeine
  - Penicillin
  - Seasonal
  - Other _____
- ☐ Anemia
- ☐ Anxiety/ Depression
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Pregnancy (currently)
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____

▪Have you been admitted to a hospital or required emergency care during the past two years? Yes ☐ No ☐

If "yes," please explain: _____

▪Are you currently under the care of a physician? Yes ☐ No ☐ *Name/Phone # of Physician*: _____

If "yes," please explain: _____

▪Are you taking medications? Yes ☐ No ☐ *Please list*: _____

_____

Dental History

▪Do you currently have any concerns/pain with your teeth or mouth? ..... Yes ☐ No ☐

If "yes," please describe: _____

▪Do your gums bleed while brushing or flossing? ..... Yes ☐ No ☐

▪Are your teeth sensitive to hot or cold liquids/foods? ..... Yes ☐ No ☐

▪Do you feel pain to any of your teeth? ..... Yes ☐ No ☐

▪Have you ever had any complications following dental treatment? ..... Yes ☐ No ☐

▪Please check the box if you have any of the following *(if so, indicate the area of your mouth and when work was done)*:

- ☐ Crowns ("caps")..... *Area of mouth& when?* _____
- ☐ Bridge/Partial ..... *Area of mouth& when?* _____
- ☐ Dentures ..... *Area of mouth& when?* _____
- ☐ Missing Teeth/Extraction *Area of mouth& when?* _____

TMJ/Headache Assessment

▪Have you ever experienced any of the following problems in your jaw?

☐ Clicking or popping ☐ Pain (joint, ear, side of face) ☐ Difficulty opening or closing ☐ Difficulty Chewing

▪Have you been in any car accidents or experienced trauma to your head and/or neck? ..... Yes ☐ No ☐

If "yes," when? _____

▪Do you have migraines or chronic headaches? ..... Yes ☐ No ☐

If "yes," how often? _____

▪Do you clench or grind your teeth? ..... Yes ☐ No ☐ Unsure ☐

Cosmetic

▪Have you ever had orthodontic work? Yes ☐ No ☐ *If "yes," when?* _____

▪What would you like to change about your smile? _____

_____

****

Dental Insurance Information *(Please present insurance card to front desk personnel)*

Primary

Insurance Company Name		Insurance Group/Plan Name	
Name of Insured Last, First Initial			Insured's Date of Birth
Patient's Relationship to Insured	Social Security #	ID #	Group #
Insured's Address Address City State Zip Code			
Insured's Employer's Name	Employer's Address Address City State Zip Code		
Insurance Claims Phone #	Insurance Claims Address Address City State Zip Code		

Secondary

Insurance Company Name		Insurance Group/Plan Name	
Name of Insured Last, First Initial			Insured's Date of Birth
Patient's Relationship to Insured	Social Security #	ID #	Group #
Insured's Address Address City State Zip Code			
Insured's Employer's Name	Employer's Address Address City State Zip Code		
Insurance Claims Phone #	Insurance Claims Address Address City State Zip Code		

Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that it is my responsibility to assert any questions or concerns about my dental treatment and/or health history, and that my inquiries set forth have been answered to my satisfaction prior to treatment. I will not hold Dr. John F. Lann, DDS or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

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

Patient Signature _____ **Date** _____

Important Information You Need To Know About Your Dental Insurance Benefits

▪ As a courtesy to our patients with dental insurance, we are happy to file claims *on your behalf* with your insurance provider; however, it is ultimately your responsibility to know your dental insurance benefits. *Your insurance contracts only with you and not Dr. John F. Lann, DDS*, therefore services that are not covered, or any balance due after your insurance pays their portion, is your responsibility. If for any reason we have not received an insurance payment within 60 days after the date of service, the balance will be due and payable by you.

▪ Be aware that coverage percentages presented by your insurance provider reflect the percentage of ***their*** maximum allowable amount, not necessarily Dr. Lann's fees. Unless we are in-network with that insurance provider, we do not always know what those maximum allowable amounts are. Not all plans are created equally and some out-of-network providers will reimburse at Dr. Lann's full fee amount, or close to, and others may pay at a much lower rate, or not at all. Again, it is your responsibility to know your dental benefits, and pay any balance not covered by your insurance provider.

▪ We are pleased to provide you an **estimate** of your benefits prior to your dental treatment. Any estimate provided by us is not a guarantee of payment by your insurance carrier, and is based on the information we have been able to obtain from your insurance carrier. Of course we do our best to obtain the most up-to-date, accurate benefit information, but there are many variables involved in this process and the information available to us is sometimes limited. If you are concerned about your out-of-pocket expense for future treatment, we highly recommend one or both of the following options:

1) We may send a formal request (or "predetermination") to your insurance company, for a benefits quote directly from them. Having this quote in writing is your safest option, as it serves as a pre-approval from your insurance provider *following their review* of our provided x-rays and other supporting documentation. This may take anywhere from 2 or more weeks.
2) If you are unable or do not wish to wait for a predetermination to be processed by your insurance provider, you have a second, but less reliable option: you may call your insurance carrier, provide them with the dental codes on your treatment plan, and ask for the maximum dollar amount they will pay for each service. They may provide you those numbers, but they are not based on any provided evidence from our office and it is not a pre-approval of coverage.

▪ A copy of this page is available upon request.

I have read and understand the above information about my dental insurance. ***I explicitly understand that I am responsible for the payment of my treatment, regardless of whether or not my insurance accepts or denies payment of a claim.***

Patient Signature _____ **Date** _____

Additional Information

Office Guidelines Regarding Payment

I acknowledge that payment is due at the time of treatment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered of a minor/child. Our office does not get involved with divorce/custody arrangements.

I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ I have read and understand the above information about payment.
Initial

***

Cancellation Guidelines

I acknowledge there is a penalty fee for cancellations made within 24 hours of appointment time, starting at $25.

_____ I have read and understand the above information about cancellations.
Initial

***

Release of Information

_____I authorize the release of my dental records and other dental information to:
Initial

1) My insurance provider for the processing of all insurance claims and predeterminations.
2) Other dental offices and/or specialists for purposes related to my dental care.
3) I authorize the release of my dental records and/or information regarding my dental care to the following person/s:

_____

I have read and understand the guidelines stated above and agree to accept responsibility as described.

Patient Signature _____ **Date** _____

John F. Lann, DDS

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review carefully. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make:

Treatment - We will use and disclose your protected health care information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health care information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment - Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations - We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the front desk where you will be asked to sign your name when you arrive. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Business Associates - We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures that May be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.

Other Permitted and Required Uses and Disclosures that May be Made without Your Consent

When Required by Law: We may use or disclose your protected health information when we are required to do so by law.

Emergencies: We may disclose your health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to the health or safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance.

Your Rights

You have the right to inspect and copy your protected health information. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you prefer, we will prepare a summary of an explanation of your health information, for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

You have the right to request alternative communications from us. You have the right to request that we communicate with you about your health information by an alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain explanations, restrictions and limitations. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the end of this Notice. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this Notice electronically.

I, _____, have received a copy of Dr. Lann's Notice of Privacy Practices.
(print name)

_____
Signature

Date: _____

For Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

___ Patient refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement