Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out the front & back of this form completely. If you have any questions, please ask us – we will be happy to help.

Welcome

Patient Information (Confidential)

Patient's Name_____ Preferred Name_____
Last First Middle I.

Address_____ City_____ State_____ Zip Code_____

Phone Numbers: Home_____ Cell_____ Business_____ Email:_____

(These phone numbers are very important in order to contact you in case of an emergency that may affect your appointment time)

Sex: M F Child___ Adult___ Single___ Married___ Separated____ Divorced____ Widowed_____

SS#_____/____/_____ Birthdate:_____/_____/_____
Only needed for Adult Patients Mo Day Year

Patient's Employer_____ City_____ State____ Dental Insurance Y N

Spouse's Name_____ Birthdate____/____/____ SS#_____/_____/_____
Mo Day Year

Spouse's Employer_____ Business Phone_____ Cell Phone_____

If patient is a minor: Mother's Name_____ Birthdate____/____/____ SS#_____/_____/_____
Mo Day Year

Father's Name_____ Birthdate____/____/____ SS#_____/_____/_____
Mo Day Year

Responsible Party

Person responsible for account _____ Relationship_____ Phone_____

Person to contact in case of emergency_____ Phone_____

Authorization and Release

I give my consent to advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by supervised staff for diagnostic purposes or dental treatment. I hereby authorize Lake Pointe Dental Group to release any and/or all of my and my families' dental records if requested by myself, my insurance company or future medical personnel.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I will be expected to meet my deductible and pay my percentage, if any that is not covered by my insurance. Anything not covered by my insurance is expected to be paid at time of service. I understand and acknowledge that I am financially responsible for the services provided for myself and my dependants, regardless of insurance coverage. I agree to pay all costs of collection including, but not limited to, reasonable attorney's fees and monthly finance charge of 1.5% interest on any unpaid balance.

Patient Signature** (or parent if minor)*_____ ***Date_____

Please fill out Medical & Dental History on the other side

Referred by:

Please let us know how you heard about us so we may thank them for referring you:

Person's Name_____ Brochure Phone Book Newspaper Ad Welcome Letter

Patient Medical History

	Yes	*No*
1. Are you under medical treatment now?..... If yes, name of physician_____	☐	☐
2. Have you been hospitalized for any operation or serious illness within the last 5 years?..... If yes, please explain_____	☐	☐
3. Are you taking any medications?..... If yes, please list medications_____	☐	☐
4. Women: Are you pregnant?.....	☐	☐
Are you taking birth control pills?.....	☐	☐

5. Are you allergic to or have you had any reactions to the following?	*Yes*	*No*
Dental Anesthetics (eg. Novocaine).....	☐	☐
Penicillin.....	☐	☐
Other Antibiotics.....	☐	☐
Sulfa Drugs.....	☐	☐
Codeine.....	☐	☐
Aspirin.....	☐	☐
Ibuprofen.....	☐	☐
Latex Rubber.....	☐	☐
Any Metals (e.g. nickel, mercury, etc.).....	☐	☐
Other (please list)_____	☐	☐

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

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
Heart Disease.....	☐	☐	Stroke.....	☐	☐	Kidney Disease.....	☐	☐
Angina.....	☐	☐	Arthritis.....	☐	☐	Liver Disease.....	☐	☐
Frequent Chest Pains.....	☐	☐	Joint Replacement.....	☐	☐	Hepatitis or Jaundice.....	☐	☐
High Blood Pressure.....	☐	☐	Diabetes.....	☐	☐	Thyroid Disease.....	☐	☐
Shortness of Breath.....	☐	☐	Asthma.....	☐	☐	ADD or ADHD.....	☐	☐
Swollen Ankles.....	☐	☐	Carry an Inhaler.....	☐	☐	Epilepsy or Seizures.....	☐	☐
Heart Valve Replacement...	☐	☐	Respiratory Problems	☐	☐	Fainting or Dizzy Spells.....	☐	☐
Heart Attack.....	☐	☐	Emphysema.....	☐	☐	Sexually Transmitted Disease	☐	☐
Heart Murmur.....	☐	☐	Tuberculosis (TB).....	☐	☐	HIV Infection or AIDS.....	☐	☐
Mitral Valve Prolapse.....	☐	☐	Hemophilia.....	☐	☐	Cancer.....	☐	☐
Heart Pacemaker.....	☐	☐	Prolonged Bleeding...	☐	☐	Radiation Therapy.....	☐	☐
Rheumatic Fever.....	☐	☐	Anemia.....	☐	☐	Chemotherapy.....	☐	☐

Patient Dental History

Would you like us to request your x-rays from your previous dentist? Dentist Name_____ City_____

What did you like most or least about your last dentist?_____

	Yes	*No*
1. Is this your first dental cleaning?.....	☐	☐
2. Are you nervous about dental appointments?..... If yes, what makes you nervous?_____	☐	☐
3. Would you be interested in relaxing medication or Nitrous Oxide (laughing gas)?.....	☐	☐
4. Are you having any discomfort at this time?... If yes, please explain_____	☐	☐
5. Has it been longer than 6 months since your last dental cleaning?.....	☐	☐

	Yes	*No*
6. Are you interested in cosmetic dentistry?....	☐	☐
7. Are you interested in tooth whitening?.....	☐	☐
8. Do you wear removable appliances?.....	☐	☐
Partial Denture Orthodontic Retainer		
9. Do you have any problems with your jaw joint (TMJ)?..... If yes, please explain_____	☐	☐
10. Have you ever been treated for periodontal disease (gum disease)?.....	☐	☐
11. Would you be interested in a breath control system?.....	☐	☐

Financing & Insurance

Financing Options

We are proud to offer several methods of payments for services including Visa, Master Card, American Express, Discover, Care Credit, cash or check. Our team is always happy to discuss and arrange terms that best fit your budget so that you may receive the quality dental care that you need and desire. Contact our Lake Pointe Dental office today to see how these financing options can work for you.

For information on Care Credit contact: http://www.carecredit.com/

Covered providers

Our Lake Pointe Dental office accepts most major insurance plans, including Military (Met Life). Our staff will assist you with your insurance paperwork and we will gladly work with you and your insurance company. Please contact our office for any questions you may have concerning your Dental Insurance at 618.628.7080

Lake Pointe Dental Group

Harold J. Bean, DDS

Seven Hills Professional Park, 1002 E. Wesley Drive, Suite 200 · O'Fallon, IL 62269 · 618-628-7080

Important dental insurance information for our patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance within 60 days, if necessary.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment to some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not on our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
5. Keeping our office informed of any changes in your insurance coverage or employment before arriving for your appointment.

Thank you for your cooperation with your dental insurance. Please sign below to allow us to file your insurance claims for you.

I hereby authorize Dr Harold J. Bean to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr Harold J. Bean. I understand I am responsible for any unpaid balance.

_____ **Date**_____

Signature of Patient/Insured.

Lake Pointe Dental Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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 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 acknowledgement
- ☐ Other (Please Specify)

_____

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_____

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Lake Pointe Dental Group

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 IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. If you pay in full (out of your pocket) for a service you receive from us, and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your

healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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 your health or safety or the health or safety of others.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: 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 practicably do so. (You must make a 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 you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.25 for each page, $12 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

Restriction: You have the right to request that we place additional restrictions on our use or 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by 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.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Harold J. Bean, Jr DDS

Telephone: 618-628-7080 Fax: 618-628-9235

E-mail: Harold@LPDental.com

Address: 1002 E. Wesley Dr., Suite 200 O'Fallon, IL 62269

Lake Pointe Dental Group

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_____

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