Patient Packet

To help us to serve you more promptly, please complete the following forms before you arrive for your scheduled visit.

Michael A. Lamp, D.D.S. (863) 385-1911

WELCOME TO OUR OFFICE

Thank you for choosing our office. In order to provide you with the highest quality and most complete health care, we ask that you please complete all of the following information. In order to assure you of the confidentially of your health information, please see our Notice of Privacy Policy that will be given to you at your first visit, or you may find it on our website at www.lampdds.com.

Last Name ______________________________ First Name _______________________ MI ______

Please circle one: Married/Single/Widowed/Other Spouse's Name ________________________

Mailing Address: ____________________________________City,State, Zip _____________________

Physical Address: (if different) ____

Birth date: ______________________ Home phone ____________________________

Social Security # ________________________________ Cell phone ____________________________

Email Address __________________________________ Employer ______________________________

How did you hear about our office? ____

Dental Insurance ____

We will need to make a copy of your dental insurance card and driver's license.

If patient is a minor or has a Power of Attorney, please fill out the following information:

Name of Responsible Party and Relationship ____

Address ____ Phone # _________________

EMERGENCY CONTACT INFORMATION (FOR ALL PATIENTS)

Name ____ Daytime phone ______________________

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for any fees associated with those procedures.

____ _____________________________________

Signature of Patient or Responsible Party **Date**

HEALTH QUESTIONNAIRE

Patient Name____________________________________Date____

1.	My last physical examination was :		
2.	Are you under the care of a physician?	Yes	No
	If so, what is the condition being treated?		
	The name and address of my physician is:		
3.	Have you had any serious illness within the past five (5) years	Yes	No
	If so, what was the illness?		
4.	Have you been hospitalized or had an operation within the past five (5) years	Yes	No
	If so, what was the problem?		
5.	Do you have or have you had any of the following diseases or problems:		
	a. Rheumatic fever or rheumatic heart disease:	Yes	No
	b. Congenital Heart disease	Yes	No
	c. Cardiovascular Disease (heart trouble, heart attack, coronary occlusion, High/low blood pressure, arteriosclerosis, stroke,etc)	Yes	No
	d. Artificial or replacement valves	Yes	No
	e. Pacemaker	Yes	No
	f. Allergy,sinus trouble, asthma	Yes	No
	g. Fainting spells or seizures	Yes	No
	h. Diabetes	Yes	No
	i. Hepatitis or liver disease	Yes	No
	j. Artificial or replacement joints	Yes	No
	k. Ulcers or stomach disorders(colitis)	Yes	No
	l. Kidney trouble	Yes	No
	m. Tuberculosis	Yes	No
SEE BACK SIDE			
	n. Immune system disorders (including AIDS,HIV,ARC)	Yes	No

o.	Venereal disease	Yes	No
p.	Have you ever taken prescribed diet pills	Yes	No
q.	Arthritis	Yes	No
6.	Have you had abnormal bleeding associated with previous extractions, surgery or trauma?	Yes	No
7.	Do you have any blood disorder such as anemia	Yes	No
8.	Are you taking any of the following medications:		
a.	Anticoagulants (blood thinners)	Yes	No
b.	Medicine for high blood pressure	Yes	No
	Please list any medications you are taking including over the counter medication: ____________________ ____________________ ____________________		
	Are you allergic to any medications including anesthetics? List allergies:	Yes	No
9.	Do you use any tobacco products and if so how much?	Yes	No
10.	Do you use alcohol products and if so how much?	Yes	No
11.	Do you have any disease, condition or problem not listed above? If so explain:		

WOMEN

12. Are you pregnant Yes No

13. Are you taking birth control or hormone therapy Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform the dentist at the next appointment.

_________________________________ _________________________________

Patient Signature Date Dentist Signature Date

FINANCIAL POLICIES AND OPTIONS

Payments Accepted

Payment is due in full at the time of service. We accept cash, check or credit card payment. Credit cards accepted in this practice are Visa, Mastercard and Discover.

Dental Insurance

Most insurance companies will not cover 100% of all dental expenses. Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding dental fees. We will be glad to process your insurance forms at no additional charge if you provide us with all the necessary information to do so.

If a **pre-determination** is processed and **received by our office** before treatment is started, we will have you pay only the portion not covered by the insurance. **However,** the insurance estimate can be affected by deductibles, yearly maximums and exclusions and is **not a guarantee of payment**. **If the final insurance payment differs from the pre-determination, you will be responsible for the difference.**

Gradual Treatment Plan

If it will be easier financially, we can plan the completion of your dental work by spreading your appointments over several months. We will arrange to do the more urgent services at the beginning of treatment.

Outside Financial Options

If you are in need of financing to complete your treatment, we offer Care Credit and the Citi Card. Ask the receptionist for an application if you would like to apply for financing.

I have read and understand the financial policies for this office. If you have any questions, please ask the receptionist before signing.

______________________________________ ________________________

Patient (or responsible party) signature Date

CANCELLATION POLICY

We ask that if it becomes necessary to cancel an appointment, that you give our office 24 hours notice. This allows us the time to make the necessary changes to our schedule and keep our office running smoothly for other patients. We understand that emergencies do arise and can cause unavoidable changes in our lives; therefore the first cancellation without proper notice will not be billed.

Recurrent cancellations occurring over a year's time will be billed at $25.00 per visit. We don't expect this policy to affect the majority of our patients.

Signature ____

Date ________________________________

Michael A. Lamp, D.D.S.
4511 Sun 'n Lake Blvd., Suite 102
Sebring, FL 33872
(863) 385-1911

You May Refuse to Sign This Acknowledgment

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

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

_______ Communications barriers prohibited obtaining the acknowledgment

_______ An emergency situation prevented us from obtaining acknowledgment

_______ Other (Please specify)

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