LAKE COUNTRY DENTAL
RAY D. SNIDER, D.D.S., and ASSOCIATES
Cosmetic, Family and Implant Dentistry

WELCOME TO OUR PRACTICE

Patient Information

Name: ______________________________ Date: __________

Address: ______________________________ City/State/Zip: __________________

Phone: HM (_____)____________ WK (______) ________________ CELL (______) ______________

Birthdate: ____________________ Social Security #: __________________ Age: ______________

Driver License #: ___________ State: _____ Please circle: Male / Female Married / Single / Divorced / Widowed

Responsible Party Information

Name: ______________________________ Social Security #: ______________________

Address: ______________________________ City/State/Zip: __________________

Phone: HM (_____) _______________ Relationship to Patient: ______________________

Birthdate: ____________________ Social Security #: __________________ Age: ______________

Employer: ______________________________ Occupation: ______________________

Business Address: ______________________________ Business Phone: ______________

How would you like to pay for today's visit? Credit Card / Check / Cash / Monthly Payments with approved credit

Insurance Information

Primary Insurance Co.: ______________________________ Phone: (_____)____________

Employer: ______________ Group #: __________________ Employee Name: ______________

Birthdate: ____________ S.S.#: __________________ Employee #: ______________________

Secondary Insurance Co.: ______________________________ Phone: (_____)____________

Employer: ______________ Group #: __________________ Employee Name: ______________

Birthdate: ____________ S.S.#: __________________ Employee #: ______________________

Getting To Know You

Are other members of your family patients at our office? YES / NO

Name(s): ______________________________ Relationship: ______________

Name(s): ______________________________ Relationship: ______________

How did your hear about our office? ______________________________

Person to contact for emergency: ______________________________ Phone: (_____) ______________

Address: ______________________________

Dental Health History (Confidential)

Reason for today's visit?: ____

Why did you leave your former dentist? ______________________ Date of last x-rays: __________

Do you have problems with any of the following:

____ Mouth Odor
____ Bleeding Gums
____ Clicking or Popping Jaw
____ Food Collection Between Teeth
____ Grinding Teeth
____ Loose Teeth or Broken Fillings
____ Peridontal Disease/Treatment
____ Cold Sensitivity
____ Heat Sensitivity
____ Sweet Sensitivity
____ Sensitivity to Biting Pressure
____ Sores or Growths in Mouth

How often do you floss? ______________________ How often do you brush? ________________

Medical History (Confidential)

Physician's Name: ______________________________ Date of Last Visit: ______________

Have you had any serious illnesses or operations? YES/NO If yes describe: ________________

____

Have you ever had a blood transfusion? YES/NO If yes give approximate date(s): ______________

(Women) Are you pregnant? YES/NO Nursing? YES/NO Taking Birth Control Pills? YES/NO

Check if you have or have had any of the following:

____ AIDS
____ Anemia
____ Arthritis, Rheumatism
____ Artificial Heart Valves
____ Artificial Joints
____ Asthma
____ Back Problems
____ Blood Disease
____ Cancer
____ Chemical Dependency
____ Chemotherapy
____ Circulatory Problems
____ Cortisone Treatments
____ Cough, Persistent
____ Cough up Blood
____ Diabetes
____ Epilepsy
____ Fainting
____ Glaucoma
____ Headaches
____ Heart Murmur
____ Heart Problems __________
____
____ Hemophilia
____ Hepatitis Type ______
____ High Blood Pressure
____ HIV Positive
____ Jaw Pain
____ Kidney Disease
____ Liver Disease
____ Mitral Valve Prolapse
____ Nervous Problems
____ Pacemaker
____ Psychiatric Care
____ Radiation Treatment
____ Respiratory Disease
____ Rheumatic Fever
____ Scarlet Fever
____ Shortness of Breath
____ Skin Rash
____ Stroke
____ Swelling of Feet or Ankles
____ Thyroid Problems
____ Tobacco Habit
____ Tonsillitis
____ Tuberculosis
____ Ulcer
____ Venereal Disease

Do you need Antibiotic Premedication prior to dental treatment? YES / NO

List medications you are currently taking: ____

Allergies: ____ Aspirin ____ Penicillin ____ Codeine ____ Local Anesthetic Other: ______________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information cab be dangerous to my health. I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to bruising, hematoma; cardiac stimulation; temporary or rarely, permanent numbness; or muscle soreness. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event any dispute or claim arising from dental treatment or insurance claims cannot be settled by parties involves, all parties agree to submit said dispute to binding arbitration.

Date: ______________ **Signature**: ________________________________

Dr. Notes: ____

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Ray D. Snider, D.D.S.,
General & Cosmetic dentistry

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Fax 817-236-8791

PAYMENT POLICY

We appreciate you choosing Lake Country Dental for your **dental care.** At the office of Ray D. Snider, D.D.S. & Associates, we value our relationship with your family and would like to offer the following as our payment policy:

In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. However, please realize that the relationship is between you, the insured, and your insurance company. If we do not receive payment from your insurance company within six weeks after submission of claim, you will be expected to pay for all dental services in full. In the event the insurance company mails you the check please forward the check to our office.

- If insurance is pending, you will receive an interim statement to let you know that the account has not been paid. A finance charge will be added to your account on any balance not paid in full within six weeks from date of service.
- Once the treatment plan and the estimated insurance benefits are reviewed with you, we require that you pay your portion in full at the time of service.
- For your convenience we accept cash, check, Visa, Discover, MasterCard, American Express and ATM Debit cards. Third Party Financing is also available. A cancelled check fee will be applied in the amount of $30.00 for any returned checks.
- When impressions are taken for an appliance, half of the fee is due when the appliance is ordered and the remaining balance paid in full when the appliance is delivered.
- Please note that parent or guardian bringing child into office on the day of service will be expected to pay for services rendered. Only if payment arrangements have been made will we see the child for treatment.
- Any cancellations or changes should be made at least 24 hours in advance. It is our policy to charge $30.00 for appointments broken within 24 hours of their scheduled time.

I have read and understand the payment policies for the office:

Patient's Name: ___________________________________

Patient's Signature: ______________________________________

Date: ____

Informed Consent
Photographs

I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care. I give my permission for such items to be used for purposes of research, education, or publication in professional journals.

Patient Signature ________________________ Date ________________

Witness _____________________________________