LifeStyle Dentistry
Dr. Robert Goldtrap

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Patient Information

Today's Date: _____

Patient Name: _____Preferred Name _____

Last First MI

☐Male ☐Female ☐ Married ☐Single ☐Child ☐Other

Social Security #:_____DL:_____

Phone (Home): _____Cell: _____Work: _____

Birth Date: _____ Email: _____

Preferred Contact Method: ☐ Home Number ☐Cell Number ☐Email ☐Text

Preferred Appointment Confirmation Method: ☐ Home Number ☐ Cell Number ☐Email ☐ Text

Preferred Method to Schedule Future Appointments: ☐ Home Number ☐ Cell Number ☐Email ☐ Text

Home Address: _____

Street City/State Zip Code

Work Address: _____

Street City/State Zip Code

Employer Name: _____ Position: _____ How long there? _____

Please list other members of your immediate family who are patients in our office_____

Referral Information

Can we thank someone for referring you?
Family Member_____
Coworker _____
Friend_____
Doctor_____

Or did you find us on your own?
___ Website
___ Insurance Company
___ Location/Drive-by
___ Post Card ____ Other_____

What is the reason for your visit today? _____

Date of Last Dental Visit: _____

- **Why did you leave your previous dentist? _____**
- **Are you interested in whitening your teeth? ☐ Yes ☐ No**
- **If you could change your smile, what would you do? _____**

We routinely use latex products for your safety. If you have a known sensitivity or allergy to latex products, please notify us prior to being called back to the treatment room.

Due to Laser, Radiation, Digital Scanning & Hipaa Compliance ONLY the patient being treated will be allowed and the treatment room & NO Cellphone Use. Thank you

HEALTH QUESTIONNAIRE

Name of person completing form (if different from patient) and relation to patient: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. All information you provide will be kept confidential

****PLEASE ANSWER BY MARKING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION**

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 check up by physician: ____/____/_____
4. Are you currently in a physician's care? ..... Y N

If so, what for? _____

Treating Physician's Name: _____ Phone Number: _____

5. Have you had any serious illness, operations, or hospitalizations? ..... Y N

If so, describe and give approximate dates: _____

_____

_____

6. Have you ever had intravenous sedation or general anesthesia? ..... Y N

Were there any adverse effects? ..... Y N

7. Do you generally tolerate dental treatment well? ..... Y N

8. **DO YOU HAVE OR HAVE YOU EVER HAD:**

A. Heart disease that was detected at birth? ..... Y N

B. Rheumatic fever or Rheumatic heart disease? ..... Y N

C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? ..... Y N

D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? ..... Y N

E. Neurological Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? ..... Y N

F. Blood Disease (bleeding disorder, anemia, 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 (hypothyroidism, tumor)? ..... Y N

K. Arthritis? (Which Joints?) ..... Y N

L. Stomach ulcers or Intestinal problems? ..... Y N

M. Glaucoma? ..... Y N

N. Frequent or recurring mouth sores? ..... Y N

O. Implants/artificial joints anywhere in your body? (Heart valve, hip, knee)? ..... Y N

P. Radiation (X-ray treatment for cancer) in head and neck region? ..... Y N

Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? ..... Y N

R. Sinus or nasal problems? ..... Y N

S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N

T. Recurrent infections of any kind? ..... Y N

*9. **ARE YOU TAKING OR USING ANY OF THE FOLLOWING**

A. Antibiotics? ..... Y N

B. Anticoagulants (blood thinners)? ..... Y N

C. Thyroid medications? ..... Y N

D. Antihistamines, decongestants? ..... Y N

E. High blood pressure or heart medication? ..... Y N

F. Steroids? ..... Y N

G. Tranquilizers, antidepressants? ……..Y N
H. Stomach or GI medications (antacids, etc.)? …….. ……Y N
I. Cholesterol reducing drugs? ……..Y N
J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers? ……..Y N
K. Weight reduction pills or diet aids (over the counter or "natural" products)? ……Y N
L. Vitamins, Natural remedies (ginko biloba, ephedra, ginseng, etc.)? ….....Y N
M. Marijuana, cocaine or other "recreational" drugs? ……Y N
N. Any other regular medications, pills, supplements or drugs? ……..Y N

***PLEASE LIST ALL CURRENT MEDICATIONS HERE** _____
_____
_____
_____
_____

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10. **ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:**
A. Local anesthetic (Novocaine -like drugs)? ……..Y N
B. Penicillin, Amoxicillin, Cephalosporins? ……...Y N
C. Other antibiotics? ……Y N
D. Barbiturates, sedatives? ……. Y N
E. Aspirin, ibuprofen, NSAIDS, or other pain medicines? …… ……Y N
F. Codeine or other narcotics or opioids? ……Y N
G. Latex? ……. Y N
H. Other allergies or reactions? …….. Y N
Please List: _____
11. Do you have hay fever, frequent skin rashes, etc.? ……...Y N
12. Do you use alcohol? How much per day? _____Y N
13. Do you smoke? …….. …..Y N
What product and how many per day? _____ For how long? _____
14. Do you use spit tobacco? ……. For how long? _____ Y N
15. Are you, or have you been, in a drug or alcohol recovery program? ……Y N
16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? …..... Y N
17. Do you wish to talk to the doctor privately about anything? ……... Y N
18. Any additional comments? _____
19. **WOMEN**
A. Are you taking birth control pills? ……Y N
B. Are you pregnant, trying to become pregnant or any chance you might be pregnant?……..Y N
C. Are you BREAST FEEDING? ……..Y N
D. Are you taking hormonal replacement? ……Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.
_____/____/_____ _____

Date **Signature of person completing form**

Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL

Thank you for choosing our practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor

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WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, APPLE PAY CARE CREDIT AND LENDING CLUB.

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ***ESTIMATED*** co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. After a statement of accounts has been sent and a balance is left on the account after 60 days, the credit card kept on file will be charged for any balance over 60 days.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portions and deductibles are due prior to treatment. In the event YOU insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, Care Credit, Lending Club or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. There will be a Cancellation fee of $50.00 if 48 hours notice is not given by the patient. Please help us serve you better by keeping scheduled appointments.

Dr. Goldtrap would like all of his patients to have knowledge of risks and benefits of dental procedures. We ask that you review the procedures listed and feel free to ask any questions. A treatment plan for all restorative work, which includes **anticipated fees** and treatment specific authorization, will be presented to you for your review and signature at the time treatment is recommended.

1. **Drugs and Medication**: Antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Risk of local anesthesia may include temporary or permanent numbness or bruising.
2. **Changes in Treatment:** During treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
3. **Removal of teeth:** Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc). The removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. Further treatment by a specialist or even hospitalization if complications arise during or following treatment would be your responsibility.
4. **Crowns and Bridges:** Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. You may wear temporary crowns, which may come off easily. You will need to be careful to ensure that they are kept on until the permanent crowns are delivered. The final opportunity to make changes to a new crown or bridge (including shape, fit, size, or color) must be done at the preparation appointment.
5. **Partials/Dentures:** They are artificial, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances, including looseness, soreness, and possible breakage. Most partials require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial fee.
6. **Endodontic Treatment (Root Canal):** There is no guarantee that root canal treatment will save a tooth. Complications can occur from the treatment and occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. Occasionally additional surgical procedure may be necessary following root canal treatment (apicoectomy). This treatment may be done with an Endodontist.
7. **Periodontal Loss (Tissue & Bone**): This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacement, and/or extractions). Any dental procedure may have a future adverse effect on your periodontal condition. This treatment may be done with a Periodontist.
8. **Implants:** They are a permanent alternative to bridges, partials or dentures. This process involves the participation of an oral surgeon or a periodontist. Fees for his/her services are separate from our service fees. This process involves several steps and could last from 2-6 months before complete (depending on healing time needed). As with crowns, color may not match perfectly with natural teeth.
9. **Sealants:** There is no guarantee that a sealant will prevent all cavities. They do, however, form a hard shield that keeps food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the back teeth. Occasionally sealants need to be replaced, since they do not last a lifetime. We do, however, warranty our sealants for 2 years as long as the patient is seen twice a year for the prophylaxis visits. Sealants can be done at any age as long as the teeth are free of decay and fillings. The doctor will determine the best time to have them done.
10. **Sedative Fillings**: Sedative fillings are temporary. They are placed if near caries exposure of the nerve is suspected. If the tooth becomes symptomatic after 4-6 weeks, it's likely the tooth will need a root canal or it may need to be extracted. If the tooth is asymptomatic after 4-6 weeks, than the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will enable the Doctor to remove the decay and restore the tooth.

Treatment risk: I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, biting sensitivity, abscess, pulp necrosis. Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal.

I have carefully read above conformed consent and fully understand all risks as it relates to my case.

Patient Signature or Guardian _____ Print Patient Name _____

Date _____

AUTHORIZATION & RELEASE: 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 healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my 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. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:
Signature of patient, parent or guardian

Authorization to Release Personal Protected Health Information to an Individual

Patient Full Name:_____

Patient Date of Birth:_____

- ***I do not authorize*** the release of any dental information to *any individual* except for treatment, payment and health care operations as specified in **Life Style Dentistry's** Notice of Privacy Practices.

- ***I hereby authorize*** the release and disclosure of my dental information to the following individuals. My authorization extends to all protected health information for general information purposes. The information that may be discussed includes but is not limited to: statements of charges or payments, records of all visits, records of visits for any and all dates, copies of records or reports provided to specialists, progress notes and consultation reports. I understand this authorization does not expire unless otherwise noted below.

(Please list the name of the individuals with whom we may discuss your protected dental information.)

Name	Relationship to Patient

This authorization is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy of fax of this authorization is as valid as the original. 3. I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. A revocation form is available from the receptionist. 4. Life Style Dentistry, its employees, officers, and dentist are hereby released from any legal responsibility or liability for disclosure of the above information to the extent of indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is not longer protected.

Patients Printed Name_____Patients Signature_____

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.

_____
{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)

_____

_____

_____