Southern Trace Dental
3495 Wedgewood Lane
CR 466 • The Villages, FL 32162
352-751-5777

New Pateint Form

Patient Name _____ **Date**_____

Social Security# _____**Gender**_____ **DOB**_____

Phone Home_____ **other number**_____

Mobile_____ **Text Yes or No**

Address_____

City_____ **State**_____**zip code**_____

Health Information

Date of Last Dental Visit_____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

List Meds Below:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

If you are a minor under the age 18

Relationship to patient_____phone number_____

Person responsible for payment_____DOB_____

Social Security#_____Address if different_____

Consent and authorization of Dental services: We appreciate the opportunity to serve you. It is our intent to provide you with the finest care possible while insuring that you fully understand procedures and treatment. To insure that your care comes first, we require your consent to Dr. Robert Lesh, to treat you under all circumstances while in this facility as follows: the undersigned on behalf of himself/herself, or minor (if applicable) hereby authorizes consent to any x-ray examination, anesthetic, medical or surgical diagnosis, treatment and/or transport to hospital care (if deemed necessary) to be rendered by Dr. Robert Lesh and Associates of Southern Trace Dental, Licensed dentists in the State of Florida.

Acknowledgement of receipt of notice of privacy practices

I (patient name printed) _____have received a copy of Southern Trace Dental Associates Notices of Privacy Practices.

For Office use only: We attempted written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: patient refused to sign_____ communication barriers prohibited obtaining acknowledgement_____ an emergency situation prevented us from obtaining acknowledgement _____ other (please Specify) _____

I have read the above conditions of treatment and payment and agree to their content: To the best of my knowledge all of the preceding answers and information are true and correct on page 1 and page 2. If I have any changes in my health, I will inform the doctors at the next appointment without fail. **I agree to pay a cancellation fee for all missed appointments and appointments that are cancelled within 48 hours, or after hours/ weekend cancellations of appointments.**

Signature of patient, parent or guardian_____Date_____

Relationship to patient: _____

Southern Trace Dental

Robert Lesh DMD

Treatment Plan Estimates

Southern Trace Dental prepares a Treatment Plan estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The treatment plan estimate is a good-faith attempt to predict the cost of your treatment based on the facts to Southern Trace Dental when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

- If you have dental insurance, It is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your treatment plan estimate of insurance benefits is based on information provided by your insurance company and by you. It is an estimate and your insurance benefits may be higher or lower than estimates. **In all cases, you are responsible for amounts not covered by your insurance.**

In all cases, Payment in full of the estimated patient portion of the fees is due when services are rendered.

- Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit.
- I understand that full payment is due at the time of service for myself and any party for whom I am financially responsible.
- I understand that it is **solely my responsibility to confirm** which treatment or procedures are covered and or paid by my insurance (including, but not limited to, any applicable exclusions, deductibles, annual or lifetime maximum, in or out of network).
- I understand that as a courtesy, Southern Trace Dental will attempt to verify my insurance coverage from information that I provide and will file **two claims** per appointment.
- I understand that although I pay my estimated patient balance on the date of service, the insurance estimate may differ from what my insurance carrier ultimately pays. I will be responsible for any amounts not paid by my insurance for any reason, and I may receive a bill/statement for a balance due which will be due immediately payable upon request.
- I understand that all insurance balances are due in 30 days. If the insurance balance is not paid within 30 days, I understand it is my responsibility to pay the balance and contact insurance company. Finance charges will accrue on all balances that are not paid within 30 days in the amount of 1.5% per month (18% per annum)
- I understand that if I fail to pay my account in full Southern Trace Dental may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment including all related reasonable attorney's fees, collection fees, and or court costs, finance charges.

I have thoroughly read, understand and agree to the above terms and conditions.

Printed Name_____

Signature of patient or authorized guardian_____

If authorized guardian, relationship to patient_____