Southern Trace Dental

Patient Name _____ **Date** _____
Social Security # _____ **Gender** _____ **Date of Birth** _____
Home phone _____ **Mobile phone** _____
Email address _____
Address _____
City _____ **State** _____ **Zip Code** _____

Health Information

Date of Last Dental Visit: _____ Reason for Visit _____

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

__ AIDS
__ Anemia
__ Artificial Joints
__ Asthma
__ Blood Disease
__ Cancer
__ Diabetes
__ Dizziness
__ Epilepsy
__ Stroke
__ Ulcers
__ Excessive Bleeding
__ Fainting
__ Hay Fever
__ Heart Disease
__ Heart Murmur
__ Hepatitis
__ High Blood Pressure
__ Jaundice
__ Kidney Disease
__ Tuberculosis
__ Codeine Allergy
__ Liver Disease
__ Mental Disorders
__ Nervous Disorders
__ Pacemaker
__ Pregnant
__ Radiation Treatment
__ Respiratory Problems
__ Rheumatic Fever
__ Sinus Problems
__ Tumors
__ Penicillin Allergy

List Current Medications Below or Provide a List:

_____ _____
_____ _____
_____ _____
_____ _____

Are you taking or have you taken in the past any bisphosphonates (Fosamax, Zometa, Boniva)? ___ Yes ___ No
Name of Primary Physician: _____ Phone Number _____
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 __ Relative __ Yellow pages __Newspaper __ Other _____
Name of person or office referring you to our practice: _____

If you are a minor under the age of 18:

Relationship to patient _____ Phone Number _____
Person responsible for payment _____
Date of Birth _____ Social Security # _____
Address (if different from patient) _____

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, (print name) _____ have received a copy of Southern Trace Dental and Associates Notice 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 ____, or 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. 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 that are cancelled within 48 hours, or after hours/weekend cancellations of appointments.**

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

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 I 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 my 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.
- 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 guardian _____
Relationship to patient _____ **Date** _____

Southern Trace Dental

Dr. Robert Lesh
3495 Wedgewood Lane
The Villages, FL 32162
(352)751-5777

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves,guardians, insurance providers and primary care physicians, unless we have authorization in writing by thepatient to communicate with others on their behalf. Please provide all family members or friends you want us tobe able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

You may opt out by checking the "Do NOT Release Information" box below.
I give the following named person(s) authorization to take messages or speak with the office of Southern Trace Dental, on my behalf regarding (please check all items authorized).

Name of authorized person(s): _____ Relationship _____
Phone number _____
__Appointments __ Financial __ Dental Treatment __ Insurance __ Other (explain) _____

Name of authorized person(s): _____ Relationship _____
Phone number _____
__Appointments __ Financial __ Dental Treatment __ Insurance __ Other (explain) _____

___DO NOT RELEASE INFORMATION TO ANYONE
I understand that my express consent is required to release any health care information. With my signaturebelow, I acknowledge and understand that this information will be kept in my medical record and the aboveparameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcareprovider(s) should I wish to change one or more contacts listed above.
Patient's Name: _____ Date of Birth _____
Signature of Patient or Authorized Representative: _____
Date Signed: _____