LODI VALLEY DENTAL LLP
Gene R. Sorensen D.D.S & Joel P. Crane D.D.S. • 105 Dale Drive • Lodi, WI 53555 • 608.592.4398 • lodivalleydental.com

Dental Patient Personal/Medical History

Name _____Soc. Sec. # _____-_____-_____ Birth date_____

Address _____Zip _____Age _____

Sex: M F Home Phone _____ Cell Phone _____ Spouse's Name_____

E-mail address_____

Who may we thank for referring you to our office?_____

Occupation _____ Employer _____Bus Phone_____

In case of emergency please notify: Name _____ Phone _____

Physician _____ Address _____ Phone _____

Parent or Guardian _____ Address (if different) _____

Name of Previous Dentist _____ Address _____

What is your present health? Good __ Fair __ Poor __ Are you having pain or discomfort at this time Yes __ No__

Circle any of the following which you have had or have at present:

Abnormal Bleeding
Alcohol Abuse
Allergies
Anemia
Angina Pectoris
Arthritis
Artificial Bones
Artificial Heart Valve
Asthma
Blood Transfusion
Cancer – Chemotherapy
Colitis
Congenital Heart Defect
Cosmetic Surgery
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack
Heart Surgery
Hemophilia
Hepatitis A (infectious)
Hepatitis B (Serum)
High Blood Pressure
HIV+ /AIDS
Kidney Problems
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pace Maker
Pneumocystitis
Psychiatric Problems
Radiation Therapy
Rheumatic Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis (TB)
Ulcers
Yellow Jaundice

ALLERGIES
Aspirin
Codeine
Dental Anesthetics
Erythromycin
Jewelry
Latex
Metals
Penicillin
Tetracycline
Other:
_____
_____
_____

Circle

Yes No Do you have any diseases or conditions not listed above? If yes, please explain:

Yes No Are you presently taking any medicine, drug or other substance? If yes, list drug, dosage and frequency
_____
_____
_____
_____

Yes No Are you now, or have you been under the care of a medical doctor during the last two years?
Yes No Have you ever been hospitalized or had surgery?
Yes No Have you ever had a reaction to a local anesthetic?

Circle

Yes No Have you ever had prolonged or unusual bleeding?
Yes No Have you ever had complications or illness following dental treatment?
Yes No Have you ever had an injury or trauma to your face or jaw?
Yes No Do you smoke or use smokeless tobacco?
Yes No Are you nervous or concerned about having dental work done?
Women: Yes No Are you pregnant now? Due Date:
Yes No Are you practicing birth control?
Yes No Do you anticipate becoming pregnant?
Yes No Have you had any complications or problems with a previous pregnancy?

Dental Treatment Desired (circle):

Check up Cavities Restored Cosmetic Bonding Missing Teeth Replaced
Cleaning Teeth Extracted Orthodontics Complete Dentures
Other:

Best Time for Dental Appointments

	Mon	Tues	Wed	Thur	Fri
AM					
PM					

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Doctor of Dentistry at the next appointment without fail. I have also read, understand, and agree to all information and conditions appearing in the "Consent and Agreement for Dental Treatment" form and have received a copy of same.

Signature of Patient, Parent, or Guardian _____ Date _____

LODI VALLEY DENTAL LLP
Gene R. Sorensen D.D.S & Joel P. Crane D.D.S. • 105 Dale Drive • Lodi, WI 53555 • 608.592.4398
lodivalleydental.com

WELCOME TO OUR DENTAL PRACTICE!

Thank you for trusting our office to provide for your dental health. Please let us share with you how we can make your visits here as comfortable as possible.

Financial Policies: *We realize that every patient's financial situation is different. For that reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve.* For our patients with dental insurance: As a courtesy to you we will file the necessary forms to help you receive the full benefits of your coverage; however, we are unable to make any guarantees on coverage or payments. Your insurance plan is an agreement between your employer and the insurance company and you are responsible for all balances not covered. Please know that we will do everything possible to see that you receive the full benefits of your policy.

Payment Options: Cash, Check, Debit or Credit Cards: We accept MasterCard, Visa, American Express and Discover.

For our insured patients, we will be happy to bill the exact difference to your credit card or debit card the day the insurance check is received in our office.

For our uninsured patients, we are happy to offer a 5% discount for all treatment paid in full prior to completion of dental work when you pay with cash or a check.

Patient Financing: *We do not extend credit through our office. We do accept* CareCredit*, which is a payment plan with no down payments, low monthly payments and competitive interest rates, with no prepayment penalties. Subject to credit approval.*

Cancellation Policy: *We are a very busy office and are usually booked out 6 to 8 weeks. Therefore, a 48-hour notice is required on all cancellations.*

Missed Appointments: *Missed appointments waste everyone's time – therefore, a $30 per half hour of appointment time will be charged to your account. This must be paid prior to any more appointments being made for you. Three missed appointments and we will no longer see you.*
We look forward to working with you to develop a plan for prevention and correction of your dental needs.

Signature_____Date_____

LODI VALLEY DENTAL LLP
Gene R. Sorensen D.D.S & Joel P. Crane D.D.S. • 105 Dale Drive • Lodi, WI 53555 • 608.592.4398
lodivalleydental.com

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.
Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.
Please read and initial the items below and sign at the bottom of the form.

1. **Treatment to be Provided**

I understand that during my course of treatment that the following care may be provided: examinations, preventive services, restorations, crowns, bridges, or other dental procedures. **Patient Initials_____**

2. **Drugs and Medications**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues: pain, itching vomiting, and/or anaphylactic shock (severe allergic reaction). **Patient Initials_____**

3. **Changes in Treatment Plan**

I understand that 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. I give my permission to the dentist to make any/all changes and additions as necessary. **Patient Initials_____**

4. I give permission to Lodi Valley Dental, LLP to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials_____**

_____ _____

Signature of Patient, Parent, or Guardian **Date**

LODI VALLEY DENTAL LLP
Gene R. Sorensen D.D.S & Joel P. Crane D.D.S. • 105 Dale Drive • Lodi, WI 53555 • 608.592.4398
lodivalleydental.com

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I also have been informed of, and given the right to review and secure a copy of your *Notices of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

_____
Print Patient Name

_____
Relationship to Patient

_____
Signature

_____
Date