

Gayle Y. Lundtvedt, D.M.D., P.C.
Family Dentistry

Welcome to our practice! Please take a moment to complete the following information so we can input your information into our system:

Last Name _____ First Name _____ Nickname: _____

Responsible Party for Patient (if minor): _____

Mailing Address: _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Marital Status S/ M/ D/ W Sex: M / F SSN ___ - ___ - ___

When did you last have a dental exam or cleaning? _____

Reason for your visit: _____

How did you hear about our practice? _____

**Insurance: Please complete the following section if you have dental insurance
Please present your insurance card.**

Policy Holder Name & Address _____

Relationship to Patient: _____ SSN: ___ - ___ - ___ Date of Birth: _____

Employer Name and Address: _____

Insurance Company Name & Address: _____

Group # _____ Family Deductible _____ Individual Deductible: _____

Secondary Insurance:

Policy Holder Name & Address _____

Relationship to Patient: _____ SSN: ___ - ___ - ___ Date of Birth: _____

Employer Name and Address: _____

Insurance Company Name & Address: _____

Group # _____ Family Deductible _____ Individual Deductible: _____

Please turn over

Medical Questionnaire:

Please check the box if you have or have had any of the following conditions:

- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer: Chemotherapy | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer: Radiation Therapy | <input type="checkbox"/> Tuberculosis/ PPD Positive |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Disorder/ Abnormal bleeding |
| <input type="checkbox"/> Drug Allergy | <input type="checkbox"/> Drug or Alcohol Abuse |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Other Tobacco |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> HIV + or AIDS | <input type="checkbox"/> Osteoporosis/ Bone Disorder (taking or have taken Fosamax, Boniva, Actonel etc.) |
| <input type="checkbox"/> Heart Disease or Defect | |
| <input type="checkbox"/> Hepatitis: Type: | |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Liver Disease | |

Please check the box if you are allergic to any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Jewelry or metals | |
| <input type="checkbox"/> Latex | |

Do you smoke or use any tobacco products: Y/ N Type of tobacco use: _____

Females: Are you pregnant? Due Date _____
Do you take birth control pills?
Are you nursing?

Please list all of the medications that you are currently taking:

Please list any disease, condition or problem that you think we should know about.

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Please enter your contact information, review the office policies, & sign at the bottom of the page.

Printed Name of Patient: _____
(parent or guardian if patient is under 18)

Address:

Please list any dependants for whom you are signing:

_____	_____
_____	_____
_____	_____

Phone Number: Home _____ Work _____ Cell: _____

Office Policies:

- We require **24 hours** notice for cancellation of all appointments. A **\$75 charge is applied for a broken or failed appointment without proper notification.** In the event of an emergency, the fee may be waived.
- Payment is due at the time services are rendered.
- If we are not contracted with your insurance company, we will gladly file your insurance forms for you. Payment in full is required at the time of service; the insurance company will reimburse you directly.
- Children are not allowed in the treatment area unless receiving treatment. Children under the age of 12 must be supervised while in the office. Those who don't comply will have the \$75 broken appointment fee applied and their appointment rescheduled.
- You are responsible for understanding your insurance benefits and limitations. We make every attempt to properly estimate your coverage and co-pays, but these are only *estimates*. You are responsible for any amount not covered by your insurance, and agree to pay any amount not covered by insurance.
- Our office participates in a program offering 90 day no-interest financing for dental treatment.
- In order to perform a thorough and comprehensive examination, we must review recent dental x-rays. X-rays will be taken at your dental appointment unless you bring with you (or have sent to us) a diagnostic quality set of X-rays taken in the last 12 months.
- Upon request, we will provide you with copies of your dental records at no charge. Copies of X-rays will be provided on a disk; if you desire printed X-rays, a \$10 charge per patient will apply.
- Our office hours are M, T, Th 8-4. We are open alternating Wednesdays and Fridays from 8-1. We are closed on weekends. Emergency visits are available after hours; there is a \$150 after-hours appointment fee.

Signature

Date

Please complete both sides of form

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520-458-4646

STATEMENT OF PRIVACY PRACTICES

Our practice is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. We are in compliance with the HIPAA legislation. We only collect the necessary personal information required to provide dental treatment and to collect payment as allowed by law. We will not share your personal health information with others without your consent.

We take every measure to ensure the privacy of your patient information. Our office and electronic systems are secure from unauthorized access, and our employees are trained to protect the confidentiality of your records. There are instances where your patient information will be shared with others in order to provide your dental care. These instances include, but are not limited to, sharing information with your dental insurance provider, dental laboratories, and dental specialists to whom you are referred.

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we have disclosed your protected information. All such requests must be in writing. We reserve the right to charge for your copies as allowed by law. If you believe that your rights have been violated, we urge you to notify us immediately. You can also notify the US Department of Health and Human Services.

We thank you for being a patient in our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

By signing below, you are stating that you understand your patient privacy rights and our policy to safeguard your privacy.

Signature

Date

Printed Name of Patient: _____
(parent or guardian if patient is under 18)

Please list any dependants for whom you are signing:

Please complete both sides of form