Summit Heights Dental Care

Dr. Nicholas LaGow, 2021 W. Michigan Ave,, Jackson, MI 49202
517.787.1380

About You

Name_____

I preferred to be called:_____

Birthdate:____/____/____ SSN:_____

Address:_____

_____

Home # (____)_____ Cell# (____)_____

Work # (____)_____ Other#(____)_____

Email:_____

Can we text/email you appointment reminders? Y N

Employer_____

Occupation_____

Hobbies_____

Previous Dentist_____

Date of last dental visit_____

How did you hear about our office?

_____

Primary Insurance

Insurance company name:_____

Insurance company phone #_____

Group #_____

Member ID_____

Insured's Name_____

Insured's DOB____/____/____ SSN_____

Insured's employer_____

Secondary Insurance

Insurance company name_____

Insurance company phone #_____

Group #_____

Member ID_____

Insured's Name_____

Insured's DOB____/____/____ SSN_____

Insured's employer_____

Account Guarantor

Person responsible for the account if other than patient :

_____

Billing Address_____

_____

DOB___/___/___ SSN_____

Employer_____

Relationship to patient_____

Home #(___)_____ Cell# (__)_____

Work # (___)_____ Other#(__)_____

Email:_____

Our Promise to our Patients

We personally promise to listen to your concerns and wishes. We promise we will use our gentle and painless approach to erase your fears and concerns about your dental care while we uncover your dazzling new smile. Our emphasis will always be on your comfort and satisfaction.

Medical History

Please respond to each question

Are you under medical treatment now?....Y N
Are you taking any prescription, over-the-counter, or herbal supplement drugs? .....Y N
If yes, please list each one:
_____
_____
Have you ever taken Fosomax, Actonel or any other bisphosphona .....Y N
Do you, or have you used tobacco?.....Y N
Do you use controlled substances?.....Y N
Has a doctor told you that you need to take antibiotics before dental treatment?.....Y N
If yes, for what? _____
Date of procedure:_____
For women: Are you using a prescribed method of birth control? .....Y N
For women: Are you pregnant?.....Y N
Are your teeth sensitive to hot or cold?.....Y N
Do you have pain in your jaw joints?.....Y N
Do you feel as if you have significant dental problems?.....Y N
Have you ever had a negative experience with previous dental work?.....Y N
Do you have any family members who wear dentures?.....Y N
Are you happy with your smile?.....Y N
Would you like to have whiter teeth?.....Y N

Please respond to each question

Are you allergic to any of the following?

Y N Penicillin
Y N Clindamycin
Y N Erythromycin
Y N Epinephrine
Y N Codeine
Y N Latex
Y N Tetracycline
Y N Any Metals
Y N Other _____
_____

Do you have, or have you had any of the following?

Y N Stroke
Y N Abnormal Bleeding
Y N Artificial Joints
Y N Liver disease
Y N Diabetes
Y N Kidney disease
Y N Seizures
Y N Thyroid problem
Y N Cardiac pacemaker
Y N Radiation therapy
Y N Cancer
Y N Chemotherapy
Y N Glaucoma
Y N Rheumatic Fever
Y N AIDS/HIV infection
Y N Hepatitis/Type_____
Y N Herpes
Y N High blood pressure
Y N Low blood pressure
Y N Respiratory problems
Y N Asthma
Y N Congenital heart defect
Y N Bleeding disorder
Y N Pacemaker

Please list all other medical conditions: _____
_____

I certify that the information I have given is compete and correct to the best of my knowledge.

Signed:_____Date ___/___/___

Financial & Cancelation Policy

We are committed to providing you with the best possible dental care! In order to achieve this, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment, give you a detailed treatment estimate, and answer any questions that we can about your insurance. As a courtesy to you, we will file claims with your dental insurance carrier on your behalf. Any portion not covered by insurance is your responsibility. Co-payment is due on the date of service unless arrangements were made in advance.

We expect that our patients honor the appointment times we reserve exclusively for them. We understand that your time is valuable and we appreciate the same respect in return. All cancelations or missed appointments with less than 48 hours notice are subject to a $30.00 fee.

I authorize my insurance company to directly pay Drs Brink & LaGow the insurance benefits otherwise payable to me. I also authorize them to release any information they deem necessary in connection with my treatment and/or the treatment of my children to my insurance company and/or other health practitioners.

Signed: _____ ***Date:*** ____/____/____

Our office is HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant. To comply with one of HIPPA's requirements, we are making available to you our Notice of Privacy Practice. Our Notice of Privacy Practice can be found on our website at http://www.smilejackson.com/docs/privacy-policy.pdf. Our Notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices. By signing below, you acknowledge that we have made available to you the Notice of Privacy Practices

Signed: _____ ***Date:*** ____/____/____