# Lin Dental

Dr. Thomas Lin D.M.D.
509 Leavenworth St.
Manhattan, KS 66502

## *Patient Information*

Name: ____________________, ________________ ____ ______________ Social Security #: ______________

Last Name First Name M.I. Nickname Birthdate: ______________________

Address: ____________________________________________________________

City: ______________________ State: _______ Zip: ____________

Sex: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Minor

Home Phone: ____________________ Cell Phone: _________________ E-Mail: _________________________

Occupation: ____________________ Employer: ___________________ Employer Phone: ________________

How did you hear about us? ______________________________________________________________________

Language Preference: ☐English ☐Spanish ☐Mandarin/Chinese ☐Other: ____________________

## *Insurance Information*

Person Responsible for Account: ________________________________,__________________________ ______

Last First M.I.

Relationship to Patient: ___________ Birthdate: _________________ Social Security #: __________________

Address (if different from patient): _____________________________________ Phone: __________________

City: ___________________________ State: _______Zip: _________ Employer: ____________________________

Insurance Company: _______________________ Member I.D. #: ___________________________

Group #: _______________________

## *Emergency Contact*

**In case of emergency, please contact:**

Name: ___________________________________ Phone: _____________________________

E-Mail: ________________________________

Relationship to Patient: _____________________ Alternate Phone: _______________________________

_________________________________ Signature of Patient/Guardian

_______________________________ Name of Patient/Guardian

__________________________ Today's Date

**Patient Name:** ________________________________

## Dental Health

Why have you come to our office today? (Ex. Pain, Checkup, etc.): ________________________________________

Previous Dentist: __________________ Last Visit: ___________ Date of last Cleaning: ____/_____/_______

Are you nervous about seeing the dentist? □ Yes □ No If yes, please explain why: ______________________

How often do you brush? ______________ Do you floss? □ Yes □ No If yes, how often? _________________

**Circle yes or no to each of the following that apply to you (Please mark each):**

Y N I clench or grind my teeth during the day or while sleeping

Y N My gums bleed when I brush or floss

Y N I like my smile

Y N I prefer tooth-colored fillings

Y N I avoid brushing part of my mouth due to pain

Y N I want my teeth whiter

Y N My gums feel tender or swollen

Y N I have problems eating

Y N I have had orthodontics

Y N I have had a facial or jaw injury

Y N I want my teeth straight

Y N I have had teeth removed

## Medical History-

**Do you or have you had any of the following? (Please mark Y or N for each)**

Y N Heart Disease

Y N Heart Murmur/Mitral Valve Prolapse

- Do you require a premedication Y N

Y N Stroke

Y N Diabetes

Y N Excessive Urination and/or Thirst

Y N Infectious Mononucleosis (Mono)

Y N Herpes

Y N Arthritis

Y N Emotional or Nervous Disorders

Y N Kidney Disease

Y N Tumor or Malignancy

Y N Cancer/Chemotherapy

Y N Radiation Treatment

Y N History of Drug Addiction (Prescription or Other)

Y N Immune Suppressed Disorder

Y N Have you ever taken Fen-Phen or Redux?

Y N Implants/Artificial Joints:

- □ Hip □ Knee □ Other: _________________
- Do you require a premedication Y N

Y N Congenital Heart Lesions

Y N I smoke or use tobacco

- If yes, how much per day? _____________ How many years? _______________

Y N I usually take premedication prior to dental treatment

Y N Liver Disease

Y N Jaundice

Y N Hepatitis Type ______

Y N Low Blood Pressure

Y N Rheumatic Fever

Y N High Blood Pressure

Y N Anemia

Y N Bleeding Disorder

Y N Tuberculosis

Y N Asthma

Y N Hay Fever

Y N Sinus Trouble

Y N Epilepsy/Seizures

Y N Ulcers

Y N AIDS

Y N Lung Disease

Y N Hearing Loss

Y N Fainting Spells

Y N Glaucoma

**WOMEN**

Y N Are you taking birth control medication?

Y N Are you or could you be pregnant or nursing?

**Do you have any other medical problems or medical history NOT listed on this form?**

________________________________________________________________________

________________________________________________________________________

| Medications You Currently Take |
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**Are you allergic to any of the following?**

(Mark Y or N for each)

Y N Aspirin

Y N Ibuprofen

Y N Sulfa Drugs/Sulfites/Sulfides

Y N Penicillin

Y N Codeine

Y N Latex, Metals, Plastics

Y N Local Anesthetics (Novocaine)

Y N Other Medications – Which ones? _____________

**Signature:** ________________________

**Today's Date:** ________________________

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## Statement of Financial Responsibility & Consent to Treatment

______________________________ ______/_______/_________
**Patient Name** **Birthdate**

The staff at Lin Dental appreciates the confidence you have shown in choosing us to provide for your dental care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulation that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for you balance in full.

I have read the above policy regarding my financial responsibility to Lin Dental for providing dental services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Lin Dental the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

### Co-Pay Policy

Some dental insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

### Consent for Treatment & Authorization to Release Information

I hereby authorize Lin Dental, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.
I agree to release Lin Dental from any and all liability from actions pertaining and relating to the administration of treatment to my child.
I further authorize Lin Dental, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

### Self-Pay

I do not have dental insurance and will be responsible for services rendered here at Lin Dental. I agree to pay the full and entire amount for treatment given to me or the above named patient.

### Acknowledgement of Receipt of Privacy Practices

I hereby acknowledge that I have received a copy of the Lin Dental Notice of Privacy Practices.

______________________________ ______________
**Patient Signature** **Date**

______________________________ ______________
**Guarantor Signature** (If guarantor is not the patient) **Date**