Lasting Smiles Dental Care

194 N. U.S. Highway 27, Suite –F
Clermont, FL 34711

Welcome to Lasting Smiles Dental Care. We are a general dental practice that blends old-fashioned service and the latest technology with professionalism and a sense of humor. We are committed to providing dental care and the finest service possible for our patients.

A healthy mouth is the gateway to a healthy body. Research has linked poor dental health to medical problems of the heart, lungs, blood vessels, gastrointestinal tract, diabetes and more. In addition to traditional preventive, restorative and cosmetic dentistry, we offer dental implants to restore missing teeth, pain-free Laser treatment and same-visit computer generated all porcelain restorations (CEREC). We are proud of our patient-centered philosophy and personalized care in this modern age of indifference, we focus on helping patients take responsibility for their oral health, on knowing each patient as an individual and on making dental visits pleasant, gentle and pain-free. Our goal is to educate our patients on the value of maintaining their natural teeth and their oral health so that they may enjoy the benefits and quality of life from a healthy, comfortable, functional and lasting smile.

OFFICE POLICIES

OFFICE HOURS – Monday to Friday 7:30am-5pm.
Hours are subject to change.

APPOINTMENTS – Dental treatment is a very personalized and time-intensive service and we reserve specific time in which to perform the procedures. When you schedule an appointment, it is your responsibility to keep that appointment. We will make an effort to contact you to remind you of your appointment, however, it is still your responsibility to show up whether you hear from us or not. If you have any questions, please call to verify. Please call at least 48 hours before your appointment and speak with a real person to cancel an appointment. If you are going to be late, please call us so we are aware of the situation. We understand that things happen, however, just as your time is valuable, our time is valuable. The charge for broken appointments with less than 48 hours notice is $50. (If a patient does not show up for an appointment for which we have reserved the time, the patient does not get the treatment needed and someone else does not get the treatment they may have needed). We accommodate emergencies for our patients of record within 24 hours. We try to accommodate all who truly want and need to be seen.

X-RAYS AND EXAMINATIONS – It is required by law that we establish a baseline and diagnosis of your oral health prior to prescribing a "cleaning" appointment or other treatment visit. X-rays and an examination help us formulate the blueprint for your care and proper sequencing. We also may need photographs and diagnostic models to help us study your particular dental issues and plan treatment.

MEDICAL HISTORY – Please be sure that you give us your complete medical history and inform us of any changes. It is your responsibility to inform us of any medical alerts or conditions and any prescribed and over the counter medications and any changes before every treatment.

CHILD VISITS - A parent needs to accompany minors under 18 years of age at the time of the appointment unless we have a written consent prior to the appointment that a relative or friend has authority.

FINANCIAL POLICY – Full payment is expected at the time service is rendered. We accept cash, checks, Visa, Master Card, Discover, American Express and Care Credit. Returned checks will be charged a $50 service fee.

I have read, had the opportunity to ask questions and understand the office policy.

Patient Signature: _____Date: _____

Welcome to Our Practice

Patient Information

Title First Name M.I. Last Name Suffix

I prefer to be called

Address City State Zip

Home Phone Cell Phone Business Phone Ext.

Preferred Contact # Social Security # **Gender** ☐ Male ☐ Female

Date of Birth / / **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you find out about us?

Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix

Relationship to Patient

Home Phone Cell Phone Business Phone Ext.

Responsible Party

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:

Title First Name M.I. Last Name Suffix

Address City State Zip

Home Phone Business Phone Ext.

Date of Birth / / Social Security # Driver's License #

Employer

Primary Insurance

Do you have a Primary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No

Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #)

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Secondary Insurance

Do you have a Secondary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No

Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #)

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Dental Information

Previous or Referring Dentist: Phone Number:
When was your last dental visit? What was done?
When were x-rays taken last? **When was your last dental cleaning?**
Reason for today's visit: **Are you in pain?** ☐ Yes ☐ No For how long?
Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
How do you feel about your smile?
How many times a day do you brush? **How many times a week do you floss?**
What type of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft
Are you fearful of dental treatment? ☐ Yes ☐ No Please explain:
Have you ever had trouble getting numb or had reactions to local anesthetic? ☐ Yes ☐ No
Please describe:

Do your gums bleed?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	☐ Yes	☐ No
Have you noticed any bad tastes or bad breath?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?	☐ Yes	☐ No
Have you had orthodontic (braces) treatment?	☐ Yes	☐ No
Does food tend to become caught between your teeth?	☐ Yes	☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes	☐ No
Do you have earaches or neck pains?	☐ Yes	☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes	☐ No
Have you noticed any loose or shifting teeth?	☐ Yes	☐ No
Have any of your family members had significant dental treatment or tooth loss?	☐ Yes	☐ No
Would you be concerned if you lost your teeth and had to wear false teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had headaches on a regular basis in the morning, evening, or after eating?	☐ Yes	☐ No
Have you had your bite adjusted?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes	☐ No
Do you participate in active recreational activities?	☐ Yes	☐ No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Date of last physical exam **Are you now under the care of a physician?** ☐ Yes ☐ No

Current Physician

What condition is being treated?
Physician Name **Phone Number**
Address City State Zip

For Women

Are you pregnant? ☐ Yes ☐ No How many weeks?
Taking birth control pills or hormonal replacement? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No
What was the illness or problem?
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No
Please list any medications (prescription or over the counter) you are taking:

Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	

Do you need antibiotics prior to receiving dental care? ☐ Yes ☐ No Reason:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date: Have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began:

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How much do you typically drink in a week?

Alergies

Are you allergic to or have you had a reaction to:

Local anesthetics	☐ Yes ☐ No	Details:	
Aspirin	☐ Yes ☐ No	Details:	
Penicillin or other antibiotics	☐ Yes ☐ No	Details:	
Barbiturates, sedatives, or sleeping pills	☐ Yes ☐ No	Details:	
Sulfa drugs	☐ Yes ☐ No	Details:	
Codeine or other narcotics	☐ Yes ☐ No	Details:	
Metals	☐ Yes ☐ No	Details:	
Latex (rubber)	☐ Yes ☐ No	Details:	
Iodine	☐ Yes ☐ No	Details:	
Hay fever/seasonal	☐ Yes ☐ No	Details:	
Animals	☐ Yes ☐ No	Details:	
Food	☐ Yes ☐ No	Details:	

Other

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive	☐ Yes ☐ No	**Excessive Bleeding**	☐ Yes ☐ No	**Mitral Valve Prolapse**	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	**Excessive Thirst**	☐ Yes ☐ No	**Pain in Jaw Joints**	☐ Yes ☐ No
Anaphylaxia	☐ Yes ☐ No	**Fainting Spells/Dizziness**	☐ Yes ☐ No	**Parathyroid Disease**	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Frequent Cough**	☐ Yes ☐ No	**Psychiatric Care**	☐ Yes ☐ No
Angina	☐ Yes ☐ No	**Frequent Diarrhea**	☐ Yes ☐ No	**Radiation treatment**	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	**Frequent Headaches**	☐ Yes ☐ No	**Recent Weight Loss**	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	**Genital Herpes**	☐ Yes ☐ No	**Renal Disease**	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	**Glaucoma**	☐ Yes ☐ No	**Rheumatic Fever**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	**Hay Fever**	☐ Yes ☐ No	**Rheumatism**	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	**Heart Attack/Failure**	☐ Yes ☐ No	**Scarlet Fever**	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	**Heart Murmur**	☐ Yes ☐ No	**Shingles**	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	**Heart Pace Maker**	☐ Yes ☐ No	**Sickle Cell Disease**	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	**Heart Trouble/Disease**	☐ Yes ☐ No	**Sinus Trouble**	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	**Hemophilia**	☐ Yes ☐ No	**Spina Bifida**	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	**Hepatitis A**	☐ Yes ☐ No	**Stomach/Intestinal Disease**	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	**Hepatitis B or C**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	**Herpes**	☐ Yes ☐ No	**Swelling of Limbs**	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	**High Blood Pressure**	☐ Yes ☐ No	**Thyroid Disease**	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	**Hives / Rash**	☐ Yes ☐ No	**Tonsilitis**	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	**Hypoglycemia**	☐ Yes ☐ No	**Tuberculosis**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Irregular Heartbeat**	☐ Yes ☐ No	**Tumors/ Growths**	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	**Kidney Problems**	☐ Yes ☐ No	**Ulcers**	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	**Leukemia**	☐ Yes ☐ No	**Venereal Disease**	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	**Low Blood Pressure**	☐ Yes ☐ No	**Yellow Jaundice**	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	**Lung Disease**	☐ Yes ☐ No		

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Please explain:

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____

Lasting Smiles Dental Care

LIST OF CURRENT MEDICATIONS

NAME: _____DATE: _____

PLEASE LIST ANY AND ALL MEDICATIONS WITH STRENGTH, DOSAGE AND REASON FOR MEDICATION.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____

Lasting Smiles Dental Care

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

We reserve the right to decline treatment if you refuse to sign this Consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Connie Godbold (privacy officer) at 352-243-0018.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____, hereby authorize Lasting Smiles Dental Care and Nadim Haidar DDS LLC
(print your name)

(hereby collectively referred to as "Practice") to use and disclose the entire medical record concerning _____. In accordance with the attached Notice of Privacy Practices (NOPP).
(print patient's name)

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. I understand that my records may be subject to re-disclosure by recipients and unprotected by federal or state law.
A copy of this signed and dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of super-confidential information as stated in the NOPP:
Initial where appropriate:

_____ Alcohol and substance abuse diagnosis and treatment records
_____ HIV records(including test results) and sexually transmissible disease
_____ Psychotherapy records

_____/_____/_____/_____
Signature | Print Name | Relationship to Patient | Date

Lasting Smiles Dental Care

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CONSENT FOR TREATMENT

1. I hereby authorize the doctors and the designated staff of Lasting Smiles Dental Care to take X-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (Name of the patient) _____ ‘s dental needs.

2. Upon such a diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.

3. I agree to use the anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understands that I can ask for complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

Patient’s Signature _____ Date _____

Parent/Responsible Party’s Signature _____ Relationship to Patient _____

Lasting Smiles Dental Care

FINANCIAL POLICY

We would like to welcome you to our office. Here at Lasting Smiles Dental Care we strive to provide you with excellent dental care and our goal is to make your visits as pleasurable as possible. Good communication concerning your dental needs, treatment procedures and fees is one of most important goals. We request payment for services at the time they are rendered. Payment for services may be made in any of the following ways: Cash, Check, Visa, Master Card, Discover, American Express or Care Credit.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current - All self-pay, estimated payments and deductibles will be collected at the time of service.
- A returned check will result in a **$50** service charge and all future payments must be paid in cash or by credit card.

IF YOU HAVE DENTAL INSURANCE COVERAGE:

Please let us know in advance. We will submit your claims, however ***we must emphasize that as a dental provider, our relationship is with you, NOT your insurance company.*** Although we attempt to verify your dental benefits with your insurance company, please be advised this is only an **ESTIMATE** of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified **before** your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what services are being provided to you and if it is a covered benefit under your insurance policy.
- If the claim is denied we may ask that you call on your own behalf. It is more likely that your insurance company will explain to you, since you are the policy holder and premium payer.
- You are responsible for any non-covered charges not payable by your insurance.

Filing your insurance claims is a courtesy extended to you. **ALL** charges are **ALWAYS YOUR RESPONSIBILITY** from the date services are rendered.

If you need any assistance with applying to a Care Credit account, our staff will be happy to guide you through the process of application.

_____	_____	_____
Patient Name (Print)	Patient/Responsible Party Signature	Date