MICHAEL T. LAVELLE III DDS PC

IMPORTANT: PLEASE FOLLOW THESE INSTRUCTIONS BEFORE FILLING OUT THE FORMS OR YOU WILL LOSE YOUR WORK!

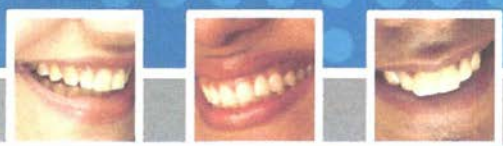
1. Download the forms (icon in the upper right) to your desktop and SAVE
2. Close the website.
3. Open the forms on your computer.
4. Fill out the forms and SAVE
5. Email as an attachment to lavelledds@gmail.com.

** **Note:** If you do not save the form to your computer first before filling it out, you will lose all of your filled out information.

Please call us at (315) 736-7822 if you have any questions. Thank you!

Michael T. Lavelle III DDS PC
165 Whitesboro Street
Yorkville, NY 13495

(315)736-7822



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.
*** Please type "NA" for any required text boxes that are not pertinent to you ***

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: * _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

You will fill this out in person at the office.

Birth Date: * _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: * _____ _____ _____ _____ _____ _____
Home Work Ext Mobile Fax Other

Address: * _____ _____

* _____ * _____ * _____
City State Zip Code

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet
☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

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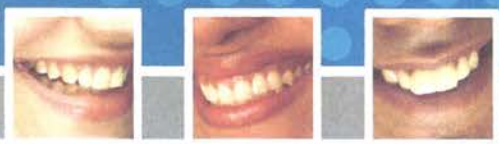

Spouse or Responsible Party Information

The following is for: * ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: * Last * First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

You will fill this out in person at the office.

Birth Date: * SS #. Driver's License #:

Email Address: Best time to call:

Phone: * Home Work Ext Mobile Fax Other

Address: *

* City * State * Zip Code

Employment Information

The following is for: * ☐ the patient ☐ the person responsible for payment

Employer Name: * Phone:

Address:

City State Zip Code

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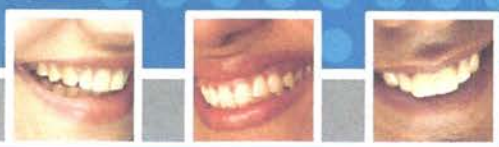

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:* _____ * _____ _____
Last First MI

Insured's Birth Date:* _____ ID #.* _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured: * ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____

_____ _____ _____
City State Zip Code

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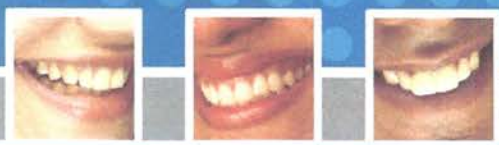

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ ____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ ____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ ____ _____
City State Zip Code

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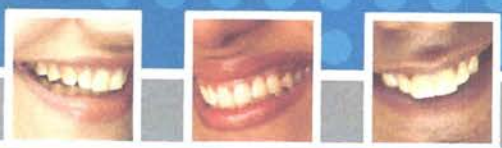

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 2.83% per month (34% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

* ☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date:*

You will sign this in person at the office.

Relationship to Patient:

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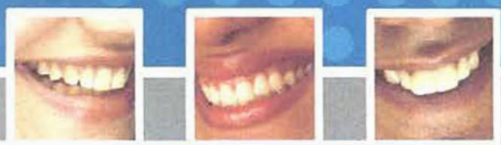

Notice Of Privacy Practices-Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting any of our staff members.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Response Date: _____

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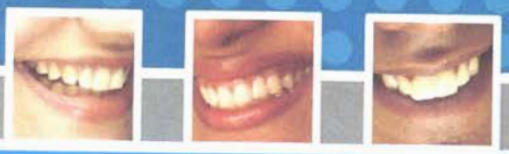

Medical and Dental History Form

***** Please type "NA" for any required text boxes that are not pertinent to you *****

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history, so we may serve you better and in a way that watches out for your over all health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Your primary care physician's name, address, and phone number:

Please mark any of the following to indicate YES in response to the question.

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (glasses or contacts)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

*

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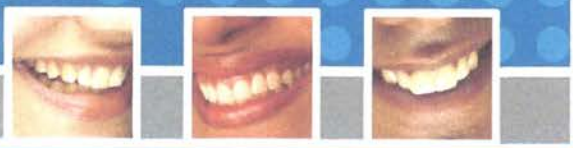

Please indicate if you have experienced any of the following:

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ Allergies	☐ Allergy - Aspirin
☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever	☐ Allergy - Latex
☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia
☐ Arthritis	☐ Asthma	☐ Blood Disease	☐ Cancer
☐ Diabetes	☐ Drug/alcohol Use	☐ Emphysema	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Fever Blisters	☐ Glaucoma
☐ Heart Defects	☐ Heart Disease	☐ Heart Surgery	☐ Hepatitis
☐ High Blood Pressure	☐ Joint Replacment	☐ Kidney Disease	☐ Liver Disease
☐ Other	☐ Pacemaker	☐ Pregnancy	☐ Psychiatric Problems
☐ Radiation Treatment	☐ Replaced Heart Valve	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Seizures	☐ Shingles	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	☐ Yellow jaundice

WOMEN ONLY;

Are you pregnant?

◯ Yes ◯ No

If yes what is your due date?

Are you nursing?

◯ Yes ◯ No

Are you taking birth control pills?

◯ Yes ◯ No

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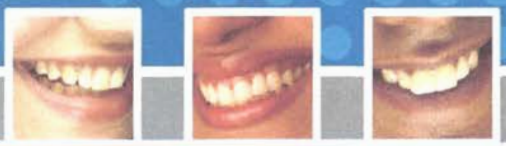

Do you have any other health issues or allergies?

*

What is your reason for your dental visit today?

*

How often do you brush your teeth?

◯ three + a day ◯ twice a day ◯ once a day ◯ weekly ◯ seldom

How often do you floss your teeth?

◯ 1 + a day ◯ 2-6 weekly ◯ 1 -6 monthly ◯ seldom ◯ never

Please mark any of the following to indicate YES in response to the question:

☐ Do your gums bleed when you brush or floss?
☐ Do your teeth experience sensitivity to cold or hot?
☐ Are any of your teeth causing you pain?
☐ Do you grind your teeth (consciously or during sleep)?
☐ Are any of your teeth loose, or you concerned about any teeth loosening?
☐ Do you currently have any dental implants, dentures, or partials?

If any of the questions are marked, please explain.

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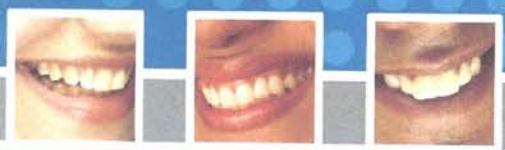


If you could change anything about your mouth, teeth or smile, what would it be?

* ☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependants (if any).

Relationship to patient:

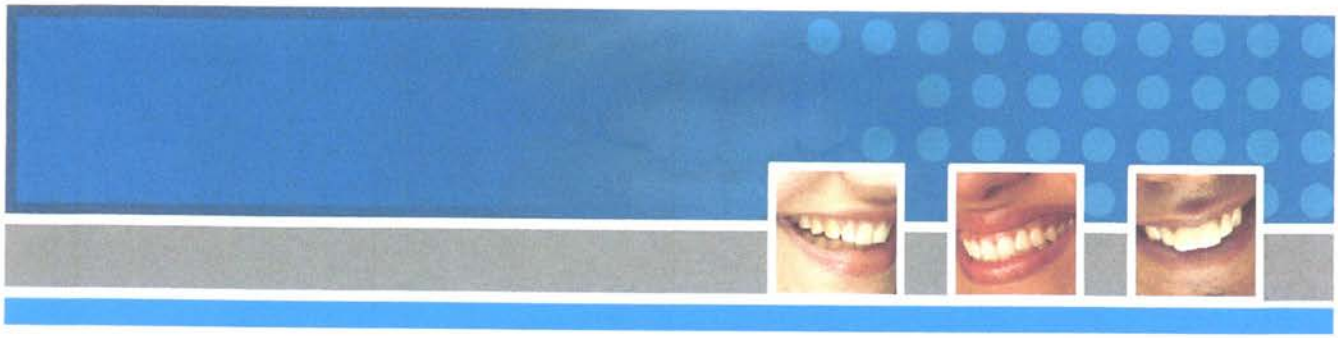
*

Signature of patient, parent, or guardian:

Signature: _____ Date: *

You will sign this in person at the office.

Response Date:



Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 2.83 % per month (34% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: _____ Date: _____

You will sign this in person at the office.

Relationship to Patient: _____