



WELCOME

Kamala Lewis DDS ND

508 E. Pierce St.
Luling, TX 78648
(830)875-2056

PATIENT INFORMATION

DATE _____

PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

SEX M F AGE _____ BIRTHDATE _____

SINGLE MARRIED WIDOWED SEPERATED DIVORCED

SS# _____ DL# _____

OCCUPATION _____

EMPLOYER _____

EMPLOYER ADDRESS _____

EMPLOYER PHONE# _____

SPOUSE/PARENT'S NAME _____

BIRTHDATE _____ SS# _____

OCCUPATION _____

SPOUSE'S EMPLOYER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP _____ DL# _____

INSURANCE CO _____

GROUP # _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? _____

IF YES, SUBSCRIBER'S NAME _____

BIRTHDATE _____ SS# _____

RELATIONSHIP TO PATIENT _____

INSURANCE CO _____

GROUP # _____

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DR. LEWIS ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE OF RESPONSIBLE PARTY

DATE

PHONE NUMBERS

HOME _____ WORK _____ SPOUSE'S WORK # _____

CELL # _____ BEST TIME AND PLACE TO REACH YOU _____

IN CASE OF EMERGENCY, CONTACT (SPECIFY SOMEONE WHO **DOES NOT** LIVE WITH YOU)

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

PREFERRED PHARMACY

PHARMACY NAME _____

CITY _____ PHONE NUMBER _____

Health History

Physicians name _____ Date of last visit _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentemine:, Pondium (fenfluramine: and Redux (defenfluramine). Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Yes No

Have you had any serious illness or operation? Yes No If yes, describe _____

Have you ever had a serious head or neck injury? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, approximate date _____

Are you on a special diet? Yes No Do you use tobacco? Yes No

Do you use controlled substances? Yes No

(Women) Are you pregnant? Yes No Date Due _____ Doctor's Name _____

Nursing? Yes No Taking birth control pills? Yes No Doctor's Phone # _____

Check if you have had any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cortisone treatment | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| | | | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Medications

List all medications you are currently taking:

Allergies

Check if you are allergic to or had a reaction to any of the following:

- Local anesthetics like Novocain
 Penicillin or other antibiotics
 Sedatives or sleeping pills
 Aspirin
 Iodine
 Latex
 Metal
 Any other thing? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian _____

Date _____

Kamala Lewis, DDS

508 E. Pierce St. Luling, TX 78648
(830) 875-2056

OFFICE POLICY

Following is a list of our new office policies in regard to your dental appointment.

1. It is **only** a courtesy to our customers that we call and confirm appointments. There may be times that we are unable to confirm your appointment.
2. A 24 hour notice **MUST** be given to change an appointment. A week notice **MUST** be given if you have made an appointment with our specialist.
3. If you fail to show or cancel an appointment without a 24 hour notice, you will be put on a cancellation list, as well as being charged a \$25.00 broken appointment fee. If your appointment was with our specialist and you fail to give a weeks notice or not show up, your fee will be \$150.00.
4. If you fail to show up at 3 appointments without a 24 hour notice, we reserve the right to no longer see you in this office.
5. You must check in at the reception desk 10 minutes before your appointment time. If you are ten minutes late, we reserve the right to reschedule your appointment to allow us adequate time to properly treat you.
6. Filing your insurance is a courtesy that our office provides for you. Luling Dental will verify coverage and benefits; however, the insurance company **WILL NOT** guarantee payment of any claim until it is processed. Any amount given to me regarding insurance is **STRICTLY AN ESTIMATE.**
7. Insurance and non-insurance patients, please understand that you are responsible for your co-pay **AT THE TIME YOU ARE SEEN.** If your insurance does not pay for your services, **YOU ARE RESPONSIBLE FOR THE TOTAL BALANCE OWED ON THE ACCOUNT.**

Please sign after reading this letter stating YOU UNDERSTAND AND ARE WILLING TO FOLLOW OUR OFFICE POLICIES.

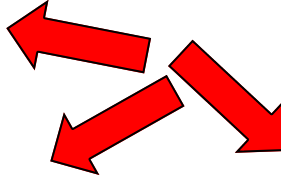
X _____
Signature of patient of responsible party

Date

**Kamala Lewis DDS
Luling Dental PLLC
ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")**

I acknowledge that I have received a copy of this Dental Practice's
HIPAA Notice of Privacy Practices.

Patient Name (Please Print)



Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ___ An emergency prevented us from obtaining acknowledgement.
___ A communication barrier prevented us from obtaining acknowledgement.
___ The individual was unwilling to sign.

Other: _____

Staff Member Signature

Date