WELCOME

Kamala Lewis, DDS
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:

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

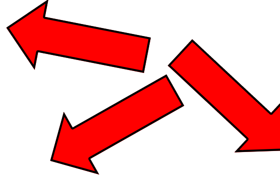
Signature of patient of responsible party Date

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