Lancaster Cleft Palate Clinic

Patient Information				
Last Name		First Name		MI
Address				
City	State	Zip	DOB	
SSN	M/ F	Email		
Home Phone		Work Phone		
Mobile Phone		Marital Status :	Married Single Divorced Widowed (circle)	
How did you hear about us?				

Responsible Party				
☐ Self	Last Name	First name		MI
Relationship to Patient :	Parent Spouse	Legal Guardian (circle)	Other:	
Address (if different from above)				
City	State	Zip	Email	
Phone			Marital Status	

Primary Insurance				
Name of Policy Holder			SSN	
Relationship to patient	Self Spouse	Parent (circle) Other:	DOB	
Employer				
Insurance Company			Dental Medical (circle)	
Policy #		Group #		

Secondary Insurance				
Name of Policy Holder			SSN	
Relationship to patient:	Self Spouse	Parent	DOB	
Employer				
Insurance Company			Dental Medical (circle)	
Policy #			Group #	

Consent to Treatment and Insurance Billing	
I hereby consent to dental/medical treatment at the Lancaster Cleft Palate Clinic. I authorize the LCPC to bill my insurance and acknowledge that I am liable for any remaining balance.	
Signature	Date

Medicare Signature on File	
Beneficiary Name	Medicare Number (include letters)
I hereby assign payment of authorized Medicare benefits to (Lancaster Cleft Palate Clinic) for any services furnished to me or my dependent by that physician or supplier. I authorize any holder of medical information about me or my dependent be released to the centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.	
Signature	Date

LIME STREET

PEDIATRIC DENTISTRY

@ the Lancaster Cleft Palate Clinic

Health History Supplement

What is your primary concern for today's visit?

Who referred you to our clinic?_____

Date of last dental cleaning (if any):_____

Please circle any of the following that apply:

Autism	Cleft Lip
ADHD	Cleft Palate
Speech delay	Cancer
Developmental Delay	Bleeding disorder
Premature birth	Difficulty with anesthesia
Complications at birth	

Is your child fully vaccinated? Yes No Don't know

Does your water at home contain fluoride? Yes No Don't know

Are there any challenges that your child has experienced in the past that may affect his/her behavior? Yes No Don't know
If yes, please explain:

Is your child undergoing orthodontic treatment? Yes No
Where?_____

Who has the legal authority to make medical/dental decisions for your child?_____

Adult signature_____

Relationship to child_____

Patient Name _____

Medical Alert _____

Lancaster Cleft Palate Clinic

MEDICAL QUESTIONNAIRE

Please complete both sides of this medical/dental history form. All information is completely confidential.

Physician's Name _____ Date of last physical exam _____

Address _____ Phone _____

Check any of the following that you HAVE HAD or HAVE at present

O Heart Disease or Attack	O Stroke	O Hepatitis/Liver Disease	O Artificial Joints
O High Blood Pressure	O Epilepsy	O Anemia	O Endocarditis
O Diabetes	O Fainting	O Epilepsy or Seizures	O Pacemaker
O Asthma	O Thyroid problems	O Arthritis	O HIV/AIDS
O Kidney problems	O Drug/Alcohol Addiction	O Psychiatric Treatment	O Hemophilia

O Other _____

YES NO

O O Have you been hospitalized during the past two years? If yes, why? _____

O O Have you ever had a major operation? Please list _____

_____

O O Have you been asked by your medical doctor to take antibiotics before dental treatment? _____

O O Have you ever taken Phen-Fen or appetite suppressants? _____

O O Have you ever taken bisphosphonates, such as Fosamax, Actomel, Boniva, Reclast, or Zometa? _____

O O Do you smoke or use tobacco products? If yes, how much and how frequently? _____

Women, are you... O Pregnant/Trying to get pregnant O Nursing O Taking birth control pills

---

Are you allergic to or have you reacted adversely to any of the following

O Aspirin O Penicillin O Barbiturates O Local Anesthesia O Codeine O Acrylic O Latex O Metals

O Other Allergies _____

Please list all medications you are currently taking

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

-over-

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A Private Nonprofit Organization Founded by Dr. H.K. Cooper, Sr.

223 North Lime Street, Lancaster, PA 17602 (717) 394-3793 (717) 396-7409 Fax www.cleftclinic.org

DENTAL QUESTIONNAIRE

When was your last dental visit? _____ When were your last dental xrays? _____

YES	NO	
O	O	Are you having any pain or discomfort? Please explain _____
O	O	Do your gums bleed while brushing and flossing? _____
O	O	Are your teeth sensitive to hot or cold? _____
O	O	Have you ever experienced any of the following problems with your jaw? Circle any that apply: Noise/Popping Pain Difficulty Opening/Closing Difficulty in Chewing
O	O	Do you have frequent headaches? _____
O	O	Do you clench or grind your teeth? If so, do you wear a guard? _____
O	O	Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____
O	O	Do you wear dentures or partials? If so, how old are they? _____
O	O	Do you have concerns about bad breath odor? _____
O	O	Are you pleased with the appearance of your teeth when you smile? _____
O	O	Have you ever had any serious problems with dental treatment? _____

_____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Patient/Guardian Signature Date

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by

_____

Doctor's Signature Date

Periodic medical/dental health reviewed by

_____

Signature Date

_____

Signature Date

_____

Signature Date

_____

Signature Date

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POLICY STATEMENT

Appointments

- If you are unable to keep an appointment, please give us 24 hours notice.
- Following the first two missed appointments without notice, you will be given appointments on a same day basis, after which we will schedule further appointments.
- Following three missed appointments without notice, you will be dismissed from care at the Lancaster Cleft Palate Clinic.
- Confirmation calls are a courtesy, you are responsible for remembering appointments.
- A parent of guardian must accompany children under the age of 18.

Payment

- Payment is expected at time of service.
    - If we participate with your insurance plan, copays are due at the time of service, please ask for an estimate. Please ask if you are unsure whether we participate with your insurance plan.
    - If we do not participate with your insurance plan or you do not have insurance, payment in full is expected at the time of service or, if multiple visits are necessary to complete the procedure, by the time treatment is complete
- There is a $30.00 charge for returned checks.

I have read and understand the policies of the Lancaster Cleft Palate Clinic.

Responsible Party _____
(SIGNATURE)

Responsible Party _____
(PLEASE PRINT)

Additional Family Members _____
(PLEASE PRINT) (PLEASE PRINT)

Additional Family Members _____
(PLEASE PRINT) (PLEASE PRINT)

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PRIVACY PRACTICES

PATIENT NAME_____

NOTICE OF PRIVACY PRACTICES

☐ I acknowledge that I have received the Lancaster Cleft Palate Clinic Notice of Privacy Practices that describes how my medical information may be used or disclosed as required by federal law.

☐ I have previously received a copy of the Lancaster Cleft Palate Clinic Notice of Privacy Practices.

_____ _____
Signature Date

PERMISSION TO DISCUSS MEDICAL INFORMATION

The privacy of your medical information is very important to us. If you wish us to discuss information about your medical condition to your family, friends, caregivers, or others, please indicate this by completing the information below.

I, _____, permit the discussion of my healthcare information for the purpose of communicating results, findings, care decisions and billing/payment information to the following individuals:

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

I understand that medical practice personnel will use their professional judgment to determine if the discussion is in my best interest if I am not present, incapacitated or in an emergency situation and that this authorization will remain in effect until revoked by me in writing.

_____ _____
Signature Date

Lancaster Cleft Palate Clinic

CANCELLATION POLICY

We make every attempt to respect your time and when you make an appointment, that time is being held just for you. We understand that emergencies happen, but ask that you contact us as soon as possible if you can not keep a scheduled appointment.

- Please give us 48 hours notice when canceling or changing an appointment. This allows us to use that time to serve someone else.
- TWO missed appointments or late notice cancellations (less than 24 business hours – Monday through Thursday) may result in a charge of $45.00, which will be billed directly to you. You will not be able to make another appointment until this charge is paid.
- After the THIRD late cancellation or failed appointment, we will provide treatment for 30 days on an emergency basis only. At that time, you are welcome to find another dental office.

You are responsible for remembering and keeping appointments. We do offer courtesy appointment reminders, either by phone or email, to help you avoid missed appointments.

Please let us know the best way to contact you!

My preferred method for confirmations and communication is:

☐ Phone number _____

This is ☐ cell ☐ home ☐ work _____

☐ Email address _____

Thank you for you cooperation. Please sign below to acknowledge your understanding of our cancellation policy.

Patient/Responsible Party _____ Date _____

AUHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT

Please print:

I, _____, parent or guardian of

_____, a minor, do hereby authorize the following name(s); (example: name of friend, grandparent, aunt, uncle, neighbor, etc.)

a._____
b. _____
c. _____

to consent for all medical & dental treatment, ie: x-ray, examination, anesthesia, medical/dental evaluation and/or treatment, surgery evaluation and/or treatment, diagnosis or care.

It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, office treatment, anesthetic administration or surgical treatment(s) which a physician/dentist, in the exercise of his/her best judgment, may deem advisable.

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided.

This authorization shall be effective until one (1) year from date signed

_____/_____/_____ _____
Date Signature of parent, guardian or other legal representative