



Dear New Dental Patient(s)

We would like to take this opportunity to thank you for wanting to become a patient at Thomas E. Langley Medical Center's Dental Department.

The following packet will need to be completely filled out, signed, and mailed back to our office if you would like an appointment. Please make sure a copy of Patient/Guardian's Driver's License and Dental Insurance card (front and back) are returned with your packet to expedite the process. If you are unable to provide us with a copy please fill out information below.

If you do not have any dental insurance we provide a sliding scale to those who qualify. In order to apply for sliding scale you must bring in Financial Documentation for everyone in your home or dwelling. **DO NOT MAIL YOUR FINANCIAL INFORMATION, PLEASE BRING IT THE DAY OF YOUR FIRST APPOINTMENT.**

The following Financial Documentation is required:

Most recent Income Tax, Social Security, Disability and/or VA benefit letter, Retirement/Pension income documentation, last 4 consecutive pay stubs, last 3 consecutive pay stubs for workers comp. and/or unemployment, Food Stamp letter showing the amount of you award, Child support letter from the court with award amount or notarized, statement from payer stating amount he/she pays, stocks, bonds, and annuities.

At your first appointment we will do a full mouth examination and take full mouth x-rays only. Fees are as follows: Exam-\$64.00 X-rays-\$179.00 Total Fee=\$243.00(Full Price)

Dental Insurance Information (If you don't have a card):

Insurance Name: _____ Insurance Telephone #: _____
Insured Name: _____ Insured DOB: _____ Insured SS#: _____
Card #: _____ Group#: _____ Insured ID: _____
Drivers License #: _____

*Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet your dental healthcare needs, please fill out this
form completely in ink. If you have any questions or need assistance
please ask us-we will be happy to help.*

Patient Information **(CONFIDENTIAL)**

Patient's Name _____
Mailing Address _____ city _____ State _____
Zip _____
Patient's Employer _____
Home Phone _____
Work Phone _____
Cell Phone _____
Date of Birth _____
Soc. Sec. # _____
Marital Status _____ Race _____ Sex _____
Emergency Contact (please do not use home phone number already given)
Name _____ Phone _____ Relationship _____

Parent/Guardian Information

Parent/Guardian Name _____
Mailing Address _____
Phone # _____
Date of Birth _____
Social Security # _____
Driver's License # _____
Parent/Guardian's Employer _____

Dental Insurance

*If you have dental insurance coverage, please let us photocopy your insurance card so that we may verify coverage.
If you do not have dental insurance you may apply for our sliding fee schedule by providing verification of household income.
Please be aware that we will file you insurance as a courtesy, however you will be responsible for any charges not covered by your policy.*

PATIENT INFORMATION

**Thomas E. Langley Medical Center
Dental Department
Permission for Treatment**

I, _____, request examination and/or treatment for myself by the personnel of Thomas E. Langley Medical Center Dental Department. The need for the examination and treatment and the possibility of undesirable side effects will be explained to me by employees of TLMC. I understand there is no guarantee or assurance concerning the results which may be obtained, however, normal prudent care will be exercised by employees of TLMC in my diagnosis and treatment.

I authorize TLMC Dental Department to release medical/dental information to my insurance carrier(s) for the purpose of paying for any services rendered to me, and to release information to another dentist, physician, or hospital to whom I may be referred.

I certify that any information given by me to TLMC is the truth to the best of my knowledge.

Patient's Signature	Date	TLMC Witness
Signature of Parent or Guardian If minor or mentally incompetent	Relationship to Patient	Address & Phone number if other than that of the patient

Appointment Policy

Dental services are available Monday through Friday from 7:30 AM to 6:00 PM.

Routine dental services are provided by appointment. If you live in Sumter County call (352) 793-5900. If you are outside the county you may use our toll free number which is (888) 298-5510. To make an appointment let the receptionist know you need the Dental Department, and your call will be transferred to the dental office.

If you are in need of urgent dental care for one specific problem, we can see you for an emergency appointment to address only that problem. To be scheduled for an emergency dental appointment you must call at 4:00PM the day before you wish to be seen on Monday thru Thursday, or Friday at 4:00 for an appointment the following Monday. We do have a limited number of emergency appointments available, so please call right at 4:00PM. Some emergency appointments may be available the day you call, but often those appointments have been filled in the previous afternoon.

Your appointment time is time set aside for you to meet with your provider. The amount of time set aside was based on your needs. Please be aware of the following:

- *You are expected to arrive on time for your appointment. Every effort will be made to see you on time. **If you are more than 10 minutes late your provider may not be able to see you.**
- ***If you cannot keep your appointment it is important to let us know 24-48 hours in advance.**
- ***Patients with 3 no shows in a year or 2 in a row will be subject to discharge.**
- ***Any patients who cancel with less than 24 hours notice more than 3 times in one year will also be discharged.**

Please be courteous to us and your fellow patients by following this appointment policy. By carefully scheduling your appointments, and by informing us ahead of time if you will not make it to an appointment, you allow us to serve you and the community better.

Patient's Signature	Date
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PERMISSION FOR TREATMENT / APPOINTMENT POLICY

**THOMAS E. LANGLEY MEDICAL CENTER
PRIVACY STATEMENT**

PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Treatment is the provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party: consultation between healthcare providers relating to a patient; or the referral of a patient for healthcare from one healthcare provider to another.

Example: A copy of your most recent lab work may be sent to a specialist that we refer you to.

Payment is the activities undertaken to obtain reimbursement for the provision of healthcare under the health plan; obtain or provide reimbursement for the provision of healthcare; and determination of eligibility or coverage and adjudication of claims; risk adjustment; billing; claims management; collection activities; obtaining payment; related healthcare data processing; review of services with respect to medical necessity; appropriateness of care; justification of charges; utilization review activities; and disclosure to consumer reporting agencies relating to collection of reimbursement.

Example: Supporting documentation from your chart may be released to your insurance company to support a claim made.

Healthcare Operations means performing any activities related to covered functions, including: conduction quality assessment; reviewing competence or qualification of healthcare professionals; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

Example: A consultant may review your medical record for appropriate documentation.

You have a right to:

- Restrict disclosures to individuals who may be involved in your care or payment related to your care
- Receive confidential communication
- Inspect and copy protected health information about yourself
- Request an amendment to your medical record
- Request an accounting of disclosures

For further information contact this facility's Compliance Officer.

Patient/Parent/Guardian Signature

Date

By signing above I acknowledge that I have received a copy of the Privacy Statement.

Identification of Migrant and Seasonal Farm Workers

IN THE PAST 2 YEARS

A. Has anyone in your family worked in agricultural labor?

YES

NO

STOP

B. Has over ½ of your family wages (income) come from field work?

YES

NO

STOP

C. Has anyone in your family moved from this area, in search of field work, to another county or state?

YES

NO If Yes how many_____

D. Has your family lived in this area and only worked during the Harvest Season?

YES

NO If yes how many_____

Thomas E. Langley Medical Center
Medical History

Patient Name: _____ **Today's Date:** _____

Physician's Name: _____ **Physician's Phone:** _____ **Date of Last Exam:** _____

Are you under medical treatment now? yes no ***If yes, what for?** _____

(If additional space is needed, please use the bottom of the page)

Have you had any serious illnesses or been hospitalized in the past five years? yes no
***If yes, what for?** _____

Do you have or have you had any of the following?

- High Blood Pressure yes no
- Heart Attack yes no
- Cardiac Pacemaker yes no
- Easily Winded yes no
- Rheumatic Fever yes no
- Swollen Ankles yes no
- Fainting/Seizures yes no
- Hay Fever/Sinus yes no
- Low Blood Pressure yes no
- Radiation Therapy yes no
- Epilepsy/Convulsions yes no
- Liver Disease yes no
- Joint Replacement yes no
- Implant yes no
- Kidney Disease yes no
- Mitral Valve Prolapse yes no
- Hepatitis/Jaundice yes no
- Respiratory Problem yes no
- Sexually Transmitted Disease yes no



- Heart Disease yes no
- Chest Pains yes no
- Heart Murmur yes no
- Stroke yes no
- Angina yes no
- Tuberculosis yes no
- Asthma yes no
- Anemia yes no
- Glaucoma yes no
- Cancer yes no
- Arthritis yes no
- Leukemia yes no
- Diabetes yes no
- Heart Trouble yes no
- AIDS/HIV yes no
- Ulcers/Reflux yes no
- Thyroid Problem yes no
- Emphysema yes no
- Mental Disorder yes no

Do you have any medical conditions that are not listed above? If so, please list: _____

Please check if there is anything you wish to discuss privately with the doctor: _____

Are you allergic to, or have you had any reactions to the following?

- Penicillin or other antibiotics yes no
- Local anesthetics (Lidocaine, Novocaine) yes no
- Sulfa Drugs yes no
- Latex rubber yes no
- Metals (nickel, silver, etc.) yes no
- Aspirin yes no
- Sedatives yes no

Do you have any allergies not listed here? yes no ***If yes, please list below:**

