Lori R. Trost, DMD, PC
Smiles of Distinction
618.281.6161
915 N. Main Street
Columbia, IL 62236

THANK YOU FOR PARTNERING WITH US
FOR YOUR DENTAL HEALTH!

If you have any questions or need assistance while filling out this form, please ask us. We will be happy to help!

Patient Information

Patient Name: ______________________________ Preferred Name: ____________
Last First Middle Initial

Male Female Married Single Child Other Date of Birth: ____________

Social Security #: ____________________ Email: ____________________

Home Phone #: __________ Work #: ______________ Cell: ______________

Drivers License #: ____________ Expiration: ______ Referred By: ______________

Mailing Address: ____
Street Apartment #

____
City State Zip

Emergency Contact Information (please include relationship and phone number):

Date of Last Dental Visit: ______________ Reason for this visit: ______________

Health & Medical Information

- ☐ ADHD/ADD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Back Problems
- ☐ Birth Control
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer/Tumors/ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Hearing Impaired
- ☐ Heart Attack/Stroke
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A, B, C
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ Jaw Problems/TMJ
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorders
- ☐ Mitro Valve Prolapse (MVP)
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ (Current) Pregnancy*
- ☐ PREMED
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach/Ulcer Problems
- ☐ Thyroid Problems
- ☐ Tobacco Products
- ☐ Tuberculosis (TB)
- ☐ Vitamins

* If you are pregnant, when is your estimated due date? ____________________

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Bleach
- ☐ Codeine
- ☐ Dairy/Lactose Intolerant
- ☐ Erythromycin
- ☐ Food Allergies
- ☐ Ibuprofen
- ☐ Latex
- ☐ Naproxen
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other

Health & Medical Information - continued

Name of Primary Care Physician, Address & Phone:

Name of Specialist (Cardiologist, Oncologist, Orthopedic Surgeon, etc.)

List all medications you are currently taking including dosage (if applicable):

Are you now under the care of a physician? Yes No

If yes, please explain: ______________________________

____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: ______________________________

____

Have you ever had any complications following any dental treatment? Yes No

If yes, please explain: ______________________________

Have you been admitted to a hospital or needed emergency care within the past two years? Yes No

If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I should ever have any changes in my health, I will inform the doctors at my next appointment without fail.

______________________________ Date: ______________

Signature of patient, parent or guardian

Acknowledgement of Receipt of Notice of Privacy Practices
(a copy will be provided in-office at your appointment)

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

Date: ______________

Spouse or Responsible Party Information

The following information is for: the patient the patient's spouse the person responsible for payment

Name: ______________________ Male Female Social Security No: ______________________

Married Single Child Other Date of Birth: ______________________

Home Phone: ______________________ Cell: ______________________ Work: ______________________

Mailing Address: ____

____
City State Zip Code

Employment Information

The following information is for: the patient the patient's spouse the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City State Zip

Dental Insurance Information

Do you have TWO dental insurances? Yes No

Primary Dental Insurance Information:

Name of Insured (subscriber of the insurance): ______________________
Last First Middle Initial

Insured's Address: ______________________
Street City State Zip

Insured's Date of Birth: ______________________ Social Security No: ______________________

Insured's Employer Name & Address: ______________________

____
Street City State Zip

Insurance Plan Name and Address: ______________________ Phone No: ______________________

____
Street City State Zip

Insurance Group No: ______________________ Subscriber ID: ______________________

Patient's Relationship to the insured: Self Spouse Child Other

Dental Insurance Information - continued

SECONDARY Dental Insurance Information:

Name of Insured (subscriber of the insurance): ______________________________
Last First Middle Initial

Insured's Address: ______________________________
Street City State Zip

Insured's Date of Birth: ____________ Social Security No: ____________ Group No: ____________

Insured's Employer Name & Address: ______________________________

____
Street City State Zip

Insurance Plan Name and Address: ______________________ Phone No: ____________

____
Street City State Zip

Patient's Relationship to the insured: Self Spouse Child Other

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs incurred in their care and 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, check or credit card at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished 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 such 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.

As service charge of one and one-half percent per month (18% per annum) on the unpaid balance due will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for any 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, or at my request, by the Doctor, I agree to pay; therefore, the reasonable value of said services to said Doctor, or his or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. 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's fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, at work or on my cellular device to discuss matters related to this form.

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

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of guarantor of payment/responsible party

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Informed Consent to Photograph

Due to educational and teaching purposes, photographs and/or video(s) are often taken of patient procedures and products. The sole purpose is for education by Smiles of Distinction. In certain cases, we would ask a special approval to display a successful "Before and After" series of photos using social media or it may be displayed on the dental office's webpage at: www.loritrost.com. All patient data - such as face, name, age, date of birth, etc. will be kept personal and confidential.

Permission/Denial to use photographs/video (initial next to your selection):

__________ **I hereby grant permission** for the use of any illustrations, photographs or imaging records, created in my case, for use in scientific and professional journals and presentation at any time during or after treatment, with complete confidentiality of my identity.

__________ **I do not grant permission** for the use of any illustrations, photographs or imaging records created in my case.

______________________________ ______________________________ ____________________
Name (please print) Signature Date

Relationship to the Patient: __________ Self __________ Parent/Guardian

Witness: ____

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Office Policies

Dental Insurance Benefits Acceptance

As a commitment to you and your dental care, our office diligently strives to stay current with dental insurance policies. Due to the ever-changing landscape of insurance benefits, it is ultimately the patient's responsibility to verify your plan's coverage and benefits.

Please understand that any treatment balance remaining after final insurance determination will be the patient's responsibility.

Dr. Lori Trost & Dr. Caroline Connolly
and Dental Team

______________________________ ______________
Patient's or Guarantor's Signature Date

Appointment Policy

We try our very best to accommodate your busy schedule and reserve a time specifically for you.

As a courtesy, you will:

- ✓ receive a reminder email or text message two weeks prior to your appointment and again three days before your appointment for you to confirm
- ✓ confirm your appointment
- ✓ notify our office at least 24-hours in advance if you need to change your scheduled time and date

Those unconfirmed and no-show appointments will be met with a $25 fee.

Dr. Lori Trost & Dr. Caroline Connolly
and Dental Team

______________________________ ______________
Patient's or Guarantor's Signature Date