Karl E. Lugus, DDS

Board Certified in Pediatric and Adolescent Dentistry

New Patient Information

Today's Date_____

Child's Last Name _____ First_____Middle _____ Nickname_____
Gender_____ Birthdate _____ Age _____ Weight_____Grade & School _____

Medication Allergies/Medical Problems_____
_____
_____

Does child live with both parents? ❑ Yes ❑ No If not, who has guardianship of the child?_____
Which siblings are also patients here? List names and ages: _____

Guardian's Name (if not parent) _____

Please complete remaining pertinent information below.

Mother's name_____Home Phone ( ) _____
Marital Status ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Other
E-mail _____Cell Phone ( ) _____
Address _____City _____ State _____ Zip_____
Birthdate _____S.S. #_____Work Phone ( ) _____
Employer _____Occupation _____
Employer Address _____City _____ State _____ Zip_____

Father's name _____Home Phone ( ) _____
Marital Status ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Other
E-mail _____Cell Phone ( ) _____
Address _____City _____ State _____ Zip_____
Birthdate _____S.S. #_____Work Phone ( ) _____
Employer _____Occupation _____
Employer Address _____City _____ State _____ Zip_____

Dental Insurance? ❑ Yes ❑ No If yes, name of insurance company: _____
Insurance Company Address: _____
Group number _____ Insured's Name _____ Birthdate: _____
We do not file secondary insurance but will gladly provide you with the necessary paperwork upon request.

Please note that parent/guardian accompanying child is responsible for payment at time of services rendered unless prior arrangement with the office is made otherwise.

Referred by / how did you hear about our office? _____

I hereby authorize insurance payment directly to Dr. Karl Lugus, and I understand all collection and attorney fees are the responsibility of the person signing below

I acknowledge that the information above is correct and hereby authorize that a thorough dental examination by Dr. Lugus and his staff be performed on my child including necessary radiographs (x-rays), photographs and other acceptable indicated methods needed to accomplish this service. Furthermore, I authorize the use of these examination findings for the purpose of teaching, research and scientific publication. I also authorize that any/all previous dental records be released and sent to this office as requested.

Signature: _____ Date:_____Patient Account Number: _____

Karl E. Lugus, DDS

Board Certified in Pediatric and Adolescent Dentistry

CHILD'S MEDICAL HISTORY

Child's Last Name _____ First _____ Middle _____ Date _____

Child's Nickname _____ Sex _____ Birthdate _____ Age _____

Child's Physician (Primary) _____ (Specialty) _____ Phone (____) _____

Address: Street _____ City _____ State _____ Zip _____

Child's Physician (Other) _____ (Specialty) _____ Phone (____) _____

Address: Street _____ City _____ State _____ Zip _____

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? NO YES PLEASE LIST _____

OTHER ALLERGIES _____

DOES YOUR CHILD NEED ANTIBIOTIC PROPHYLACTIC PREMEDICATION BEFORE DENTAL TREATMENT? NO YES NOT SURE

Is your child in good health? ( ) No ( ) Yes

Date of last medical exam _____

Is your child under the present care of their physician? ( ) No ( ) Yes

For what reason _____

Does your child currently have or has had any contagious viral or bacterial infection within past 2 weeks? ( ) No ( ) Yes

Explain _____

Is your child taking any medications? ( ) No ( ) Yes

Please List _____ For What Reason _____

Does your child have present or history of emotional, behavioral, or learning disorder? ( ) No ( ) Yes

Explain _____

Has your child ever been hospitalized? ( ) No ( ) Yes

For What Reason _____

Has your child ever had a blood transfusion? ( ) No ( ) Yes

For What Reason _____

Has your child had tonsils and/or adenoids removed? ( ) No ( ) Yes

Which _____ When _____

Is your child current with tetanus immunization? ( ) No ( ) Yes

Date of last booster _____

Indicate whether your child presently has or previously had any of the following conditions:

No	Yes		No	Yes		No	Yes		No	Yes	
___	___	Adrenal disorder	___	___	Congenital Birth Defect	___	___	*** Heart Condition**	___	___	Muscle disorder
___	___	Aids/A.R.C.	___	___	Convulsions/Seizures	___	___	*** Heart Murmur**	___	___	Nose/throat disorder
___	___	Anemia	___	___	Cleft Lip/Palate	___	___	Hemophelia	___	___	Prolonged illness
___	___	Apnea	___	___	Diabetes	___	___	Hepatitis	___	___	Radiation treatment
___	___	Asthma	___	___	Down's Syndrome	___	___	High blood pressure	___	___	*** Rheumatic fever**
___	___	Autism	___	___	Ear disorder	___	___	Immune disorder	___	___	Sight disorder
___	___	Behavior/learning problems	___	___	Emotional disorder	___	___	Jaundice (other than birth)	___	___	Skin disease
___	___	Bleeding disorder	___	___	Eye disorder	___	___	Kidney disorder	___	___	Speech disorder
___	___	Blood disease	___	___	Fainting	___	___	Liver disease	___	___	Stomach disorder
___	___	Blood transfusions	___	___	Headaches	___	___	Lung disease	___	___	Tumor(s)
___	___	Bone disorder	___	___	Hearing disorder	___	___	Mental retardation	___	___	*** Ventricular shunt**

Please clarify on any additional information regarding your child's health which you feel is important: _____

_____

_____

Thank You.

Parent/Guardian Signature _____ Relationship _____

Please Print Name _____ Date _____

Karl E. Lugus, DDS

Board Certified in Pediatric and Adolescent Dentistry

CHILD'S DENTAL HISTORY

Child's Last Name _____ First _____ Middle _____ Date _____

Child's Nickname _____ Sex _____ Birthdate _____ Age _____

Is this your child's first dental visit? ( ) No ( ) Yes

Previous Dentist _____

Name Address Phone #

Date of last dental visit _____ For what procedure _____ X-Rays Taken ( ) No ( ) Yes

If yes, what type? _____

Did you request that your records be sent to our office? ( ) No ( ) Yes

Does your child have a dental condition which concerns you? ( ) No ( ) Yes

Explain _____

Has your child previously experienced an unpleasant dental visit? ( ) No ( ) Yes

Explain _____

Has your child previously had Orthodontic treatment? ( ) No ( ) Yes

At what age _____ Name of Dentist _____ Specialty _____

Has your child ever suffered a severe blow to the face, teeth or jaw? ( ) No ( ) Yes

When _____ Explain _____

Does your child grind their teeth? ( ) No ( ) Yes

Does your child suffer from jaw joint (TMJ) problems? ( ) No ( ) Yes

Explain _____

Does your child routinely breathe with mouth open? ( ) No ( ) Yes

When? _____ What percent of time? _____

Is your child presently on a bottle? ( ) No ( ) Yes

When/how often _____ At what age stopped? _____

Does your child presently suck or have a history of sucking thumb/fingers/pacifier/other? (circle one) ( ) No ( ) Yes

Which one(s)? _____ How often? _____ At what age stopped? _____

Are your child's teeth brushed by parents?____ Child?____ Both?____ How many times daily? _____ When? _____

Does your child use a flouridated toothpaste? ( ) No ( ) Yes

Is your child receiving flouride tablets/drops/vitamins/oral rinse? ( ) No ( ) Yes

Please list _____ When/how often received _____

Does your child drink fluoridated water? ( ) No ( ) Yes ( ) Not Sure

Does your home have a water filter/purifier? ( ) No ( ) Yes

How do you feel your child will react to dental treatment? _____

Explain _____

Does your child have any emotional/behavioral condition that you feel will affect dental treatment? ( ) No ( ) Yes

Explain _____

Please feel free to comment on any information you feel might be of value to us regarding your child's dental treatment:

_____

_____

Thank You.

Parent/Guardian Signature _____ Relationship _____

Please Print Name _____ Date _____

Karl E. Lugus, DDS

Board Certified in Pediatric and Adolescent Dentistry

PATIENT AGREEMENT FOR COMMUNICATION

I understand that as part of my dental care Dr. Karl E. Lugus will need to contact me from time to time in order to remind me of an appointment, giving instructions, discuss insurance or billing questions, or to provide other information.

I authorize Dr. Karl E. Lugus to contact me in the following ways (check those which you authorize):

_____Home Phone Voice mail OK_____

_____Work Phone Voice mail OK_____

_____Cell Phone Voice mail OK_____

_____E-Mail

_____Text

I understand that Dr. Karl E. Lugus will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

_____ _____

Patient name Date

_____ _____

Parent signature/Guardian signature Date

770.995.3220
749 Old Norcross, Suite A
Lawrenceville, Georgia 30046

fax 770.995.5226
KLugus@KarleLugusDDS.com
www.KarleLugusDDS.com

Karl E. Lugus, DDS
Board Certified in Pediatric and Adolescent Dentistry

Date:_____

Patient's Name:_____

Patient Consent for use and disclosure of Protected Health Information (PHI)

I hereby give my consent for D. Karl E. Lugus to use and disclose (PHI) about my chld/children in order to carry out dental treatment and payment procedures. Dr. Karl E. Lugus' Notice of Privacy Prctices provides a more completed description of such uses and disclosures, and this document has been made available to me for comment and review.

Parent/Guardian signature:_____

Witness:_____

Privacy Policies

It is the policy of Dr. Karl E. Lugus that all providers and staff preserve the integrity of the confidentiality of our patient's PHI. Photos may be taken during surgical procedures for insurance verification, education seminars and general documentation. Dr. Karl E.Lugus' Privacy Policy provides a more complete description of confidentiality and authorization for disclosures, and this document has been made available to me for my comment and review.

Parent/Guardian signature:_____

Witness:_____

Financial Policy

Dr. Karl E. Lugus will provide you with the most up to date care available. We ask that you as our valued patient provide us with a recent dental insurance card and valid drivers license for duplication. We will give you an estimated amount that you will be required to pay at the time of service, and we will submit your charges to your insurance carrier. You are ultimately responsible for all services rendered by this office regardless of your insurance coverage.

Parent/Guardian signature:_____

Witness:_____

770.995.3220
749 Old Norcross, Suite A
Lawrenceville, Georgia 30046

fax 770.995.5226
KLugus@KarleLugusDDS.com
www.KarleLugusDDS.com