Medical History

Patient Name: _____ Date of Birth: _____

Are you under the care of a physician now? _____

If so, for what condition? _____

Physician's name: _____ Clinic: _____ Phone #: _____
My last physical examination was: Date: _____ Result: _____

What surgeries have you had? _____

Are you taking any medications or pills of any kind, prescription or non-prescription? _____
If yes, list name and condition:

_____ _____
_____ _____
_____ _____

Nutritional supplements? _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY ILL EFFECTS FROM ANY LOCAL ANESTHETIC OR OTHER DRUG, OR MEDICINE? _____

Allergies to: Tetracycline/ Penicillin/ Sedatives/ Aspirin/ Latex/ Metal
Other _____

HAS YOUR PHYSICIAN RECOMMENED ANTIBIOTIC PROPHYLAXIS BEFORE DENTAL VISITS? _____

If so, what for _____

Have you ever had cardiac trouble/ heart attack/ stroke/ TIA/ pacemaker or defibrillator?
Date: _____
Have you had heart surgery/ angioplasty/ heart valve replacement/ stents?
If so, date: _____

Chest pains upon exertion? Do you get short of breath easily?_____

Has your blood pressure been checked in the last year? _____ Results? _____

Have you taken steroid therapy or cortisone in the past year? _____

Do you bruise easily/take any blood thinners? _____

Have you had abnormal bleeding from a cut or tooth extraction? _____

Have you had bisphosphonate therapy (i.e. Fosamax/zometa) in the past 15 years? _____

Do you use tobacco? _____

FEMALE: Are you taking oral contraceptives? _____
Are you nursing? _____ Do you think you are pregnant or are you pregnant at this time? _____
Approximate due date: _____

HAVE YOU EVER HAD? (Please mark yes or no)

Yes	No		Yes	No	
___	___	Hepatitis or Jaundice/ Type___	___	___	Rheumatic Fever
___	___	Immune Suppressed/Auto-Immune condition	___	___	Anemia
___	___	Total hip or knee joint replacement Date:_____	___	___	Blood diseases/disorders/Leukemia
			___	___	Circulatory problems
___	___	Blood Pressure: HIGH	___	___	Asthma
___	___	Blood Pressure: LOW	___	___	Tuberculosis
___	___	History of heart murmur	___	___	Bronchitis/Emphysema
___	___	Thyroid Problem	___	___	Glaucoma/cataracts/blindness
___	___	Kidney or Liver involvement	___	___	Chronic sinus
___	___	Epilepsy/seizures/convulsions	___	___	Venereal disease/Herpes II/HPV
___	___	Fainting spells/dizziness	___	___	Sleep apnea
___	___	Chronic headaches/migraines	___	___	Back problems
___	___	Psychiatric care/ emotional concerns	___	___	Hives/ skin rash
___	___	Autism/Asperger's Syndrome	___	___	Aneurysm
___	___	Diabetes Type I or II	___	___	Atrial fibrillation (with Coumadin)
___	___	Radiation therapy/ Chemotherapy	___	___	Osteoporosis/ Osteopenia
___	___	Any form of tumor/ malignancy Date: _____ Description: _____	___	___	Hearing problems
			___	___	Arthritis
			___	___	Xerostomia (dry mouth)
___	___	TMJ/jaw joint disorder	___	___	Heartburn/ gastric reflux/ ulcers
___	___	Bulimia/ anorexia/ other eating disorder			
___	___	Substance abuse: alcoholism/ drug addiction			

Is there anything else I should know about your health history or you would like to speak with Dr. Lesch about in private? _____
_____

I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Date: _____ Signature: _____

Dr. James F. Lesch _____ ASA I II III

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT

Name_____

Address _____

Telephone_____

_____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. These changes may apply to any of your protected health information that we maintain.

You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting:

James Lesch
Telephone: 952-469-5213
20785 Holyoke Ave. W., P.O. Box 310
Lakeville, Minnesota 55044-0310

Consent Does Not Expire after One Year. By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

SIGNATURE

I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name:_____
NOTE: A parent is considered a Personal Representative for a minor under the HIPAA Privacy Regulations.

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

JAMES F. LESCH, D.D.S.

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of this Practice not to release confidential medical and health information regarding your treatment to family members or friends, except for 1) parent/legal guardian; 2) other persons authorized by the patient; 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretakers/babysitters, please sign below so that we can release that information to that person. If you do not want any of your medical or health information provided to a family member or friend, please circle the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the Practice in reliance on your original authorization.

If you wish to cancel or change this agreement, please issue a letter in writing to this Practice.

	Health Care Information	Financial Information
Spouse_____	Yes/No	Yes/No
Parent_____	Yes/No	Yes/No
Other_____	Yes/No	Yes/No
_____	Yes/No	Yes/No

PRINTED NAME:_____

Patient/Parent/Guardian Signature_____

Date: _____

Patient Information

Date:_____
Patient Name: _____ Date of Birth: _____
Nickname:_____ Sex: M or F
Address:_____
City: _____ State: _____Zip code: _____
Home Phone:_____ Work Phone:_____
Cell Phone: _____
Email :_____
Employer:_____ Occupation:_____
Whom may we thank for referring you to our office?_____
IF A MINOR, parents names:_____
School:_____ Grade:_____
IF MARRIED: Spouse's name:_____
Birthday:_____

EMERGENCY INFORMATION
Name of the nearest relative/friend:_____
Phone #:_____

Financial Agreement

- Dental services provided by our office are an agreement between the patient and the doctor.
- Patients who do not have insurance are required to pay at the time of service.
- Patient portion, for those that utilize dental insurance, is due at the time of your appointment. For services that require multiple visits, payment is due at the first visit.
- **The insurance relationship constitutes an agreement between the insurance company and the patient. Patient is responsible for understanding the terms and limits of his/her benefits.**
- The parent who requests treatment for the child is responsible for all fees for services rendered.
- I understand that where appropriate, credit bureau reports may be obtained.
- I also understand that a finance charge of 1.5% will be assessed for accounts over 60 days.
- Delinquency- In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 35% of the balance due), along with reasonable attorney fees and court costs incurred by this office, in addition to your unpaid balance.

Signature: _____

Treatment
I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids mutually agreed upon which are deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Signature:_____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:
Insured's name:_____ Insured's ID#:_____
Insured's birthday:_____ Insured's employer:_____
Insurance company:_____ Insurance telephone #:_____
Address of insurance company:_____
Group/Plan#:_____ Is insurance for: Yourself Spouse Dependent
Benefits: Max_____ Ded_____ Month/Month_____
Prev_____ Basic_____ Major_____
SECONDARY DENTAL INSURANCE: YES NO
Insured's name:_____ Insured's ID#:_____
Insured's birthday:_____ Insured's employer:_____
Insurance company:_____ Insurance telephone #:_____
Address of insurance company:_____
Group/Plan #:_____ Is insurance for: Yourself Spouse Dependent
Benefits: Max_____ Ded_____ Month/Month_____
Prev_____ Basic_____ Major_____

Patient is responsible for understanding the terms and limits of his/her insurance benefits.

INSURANCE SIGNATURE ON FILE
The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed this particular claim.
Authorized signature of covered person/employee:_____

RECORDS RELEASE
In the event I or Dr. Lesch request my records to be transferred to another dental provider, I authorize the release of my records in advance.

Signature: _____

CONSENT FOR CONTACT
Dr. Lesch or his designated staff member may contact me by phone, text or email with reminders to schedule an appointment for any treatment not completed or to schedule a hygiene visit.

Signature: _____

James F. Lesch, DDS
20785 Holyoke Ave W
PO Box310
Lakeville, MN 55044
952-469-5213

Records Release Request

Please forward the records from the patient(s) listed below to our office for continuing dental care:

I, _____hereby authorize and request the release of dental x-rays of the following person(s):

_____ D.O.B. _____

_____ D.O.B. _____

_____ D.O.B. _____

_____ D.O.B _____

Please include most recent FMX/pan or BWX taken within 6 years and copies of the last three periodontal probings for each patient.

Date: _____

Signature: _____

Thank you!

Former D.D.S. Name, Location and Phone:

_____

_____

If digital please email to admin@jamesleschdds.com
Fax# 952-469-1385

COVID-19 PANDEMIC DENTAL TREATMENT
NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray, which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment willingly for myself or minor family members. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit, I agree to contact this office should I experience COVID-19 virus in the future.

I have read and understand the information stated above.

Printed Name:

Signature : Date