



SAMPLE FORM :

Name		DOB	Date	Date of Appt
Street:		City:	State:	Zip
Home Phone:		Work Phone:	Cell Phone:	
Appointed for:		Referred by:		
Previous DDS:		Preferred method of contact:		Allergies:
Last dental visit:		X-rays available:		Date of request:
Medical concerns:			Pre Med:	
DENTAL INSURANCE:			Dental concerns:	
Ins Co Name:		Employer & address:		
Ins Co. & address:			ID# or SS#:	

Protocol for Comprehensive Exam

- **Pre-Clinical**

1. Administrative

- a. Telephone contact

- Is patient in pain?
- Yes - emergency protocol
- No - continue with new patient protocol
- Ask patient: Whom may we thank for referring patient?
- Patient name (parent name also, if child)
- Mailing address/Home address
- Telephone numbers - Home/Work/Cell
- Date of last visit to dentist
- What was that visit for?
- When was last dental x-rays taken and where?
- Any dental benefit available to help facilitate some of the cost of their dentistry?

Explain to patient that the initial visit will consist of:

A Comprehensive oral examination by Dr. _____

All pertinent information will be collected in order to develop a proper diagnosis and sequence any future visits for each individual.

- b. Office contact

- Greet patient and welcome them to our office
- Have patient complete all needed paper work and make copy of health history to give to Hygienist (if not already completed ahead of time)

- **Clinical**

1. Hygienist meets patient and welcomes them to our office
2. Hygienist takes patient to the operatory
3. Hygienist introduces Dr. to patient and explains to patient the Dr will be working with them a little later
4. Hygienist conducts interview with patient
5. Hygienist/Assistant completes charting, muscle exam, probing, intra-oral photos, diagnostic films and study models if needed
6. Dr. will do thorough comprehensive exam



7. Next appointment will be made; hygiene appointment if restorative class I patient, consult if class II, III, or IV

**The Design of Your Plan
May Pay Differently
In This Office**



ENERGY. POSITIVITY. IMPACT.

90-Day reply letter

Date _____

FINAL NOTICE – BALANCE DUE: \$ _____

Name _____
Address _____
City, State Zip _____

Dear _____,

Normally, at this time, because your account is long past due, it would be placed with our collection attorney which could possibly affect your credit by placing a lien on property or garnishment of wages. However, we would prefer to hear from you regarding your preference in this matter.

PLEASE INDICATE YOUR CHOICE AND RETURN THIS FORM:

- 1. Please find enclosed my payment in full.
- 2. Please charge the balance owed to my VISA, MASTERCARD, DISCOVER CARD. (Circle which Card.)
ACCOUNT NUMBER _____
EXPIRATION DATE OF CARD ____/____
AUTHORIZING SIGNATURE _____
- 3. I will have payment in full in your office within two weeks.
- 4. I will call this week to make payment arrangements.
- 5. I do not feel I owe the amount billed. If you do not feel you owe the amount billed please explain below.
- 6. I do not intend to pay the bill. Please turn my account over for collection. FAILURE TO RETURN THIS FORM OR TO MAKE PAYMENT WITHIN TWO WEEKS WILL INDICATE YOU DO NOT INTEND TO MAKE PAYMENT.
- 7. COMMENTS:

Please do not hesitate to call if you have any questions regarding this matter.

Sincerely,

Financial Administrator for:

Healthcare Enterprises, Inc. www.ljbseminars.com
Lois Banta lois.banta57@gmail.com

LJB Seminars
816-223-3529