Cosmetic and Restorative Family Dentistry

Patient's Name:_____ Patient's Birthdate: _____
(FIRST, MIDDLE, LAST)

Patient's SS No:_____ Patient's Email Address: _____

Patient's Phone No.: Home_____ Cell_____ Work_____

Patient's Address: _____

Patient's Employer: _____

Spouse's Name:_____ Spouse's Employer: _____

How did you hear about our office? _____

Emergency Contact's Name & Phone No: _____

DENTAL INSURANCE INFORMATION

Primary Insured's Name:_____ Insured's Date of Birth: _____

Insured's Employer:_____ Insurance Company: _____

Insurance Company's Address: _____

Insured's SS No:_____ Policy No:_____ Group No: _____

Insured's Relationship to Patient:_____ Original Effective Date: _____

Secondary Insured's Name:_____ Insured's Date of Birth: _____

Insured's Employer:_____ Insurance Company: _____

Insurance Company's Address: _____

Insured's SS No:_____ Policy No:_____ Group No: _____

Insured's Relationship to Patient:_____ Original Effective Date: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party's Name & Relationship to Patient: _____

Responsible Party's SS No:_____ Responsible Party's Birthdate: _____

Responsible Party's Phone No: Home_____ Cell_____ Work _____

Responsible Party's Address: _____

I authorize the staff of Cosmetic and Restorative Family Dentistry to perform any necessary services needed during diagnosis and treatment. I also authorize Cosmetic and Restorative Family Dentistry to release any information required to process insurance claims.

I understand the information provided in this form and guarantee that it was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

PATIENT'S SIGNATURE (or Responsible Party) **DATE**

MEDICAL HISTORY

Medical Doctor(s):_____ Phone: _____

List all medications you are currently taking, and why you are taking them: _____

_____

Allergies (Please List): _____

Are you allergic to any of the following: _____ Latex _____ Penicillin _____ Dental Anesthetics

Please List Any ***Surgeries or Hospitalizations*** you have had: _____

_____

Are you pregnant or nursing? Y / N (Due date:_____) Are you taking birth control pills? Y / N

Do you use tobacco? Y / N Type: Smoke / Chew / Dip How often? _____ For how many years? _____

Do you have: Headaches? Y / N Back pain? Y / N Neck pain? Y / N Jaw pain? Y / N

If yes, How often: EVERYDAY / WEEKLY / OCCASIONAL If yes, Severity of pain: MILD / MODERATE / SEVERE

Is there anything you want to talk to the doctor about today? _____

_____

Do you have or have you had any of the following conditions? **(MUST CIRCLE Y or N)**

Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis / Rheumatism
Y N Artificial Heart Valves
Y N Artificial Joints / Replacement
Y N Asthma
Y N Bacterial Endocarditis
Y N Bleeding Problems
Y N Cancer or Tumors
Y N Chemotherapy / Radiation
Y N Chest Pains / Angina
Y N Cold Sores / Fever Blisters
Y N Congenital Heart Defect
Y N Congestive Heart Failure
Y N Diabetes
Y N Emphysema
Y N Fainting / Seizures / Epilepsy
Y N Glaucoma
Y N Heart Attack
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery / Pacemaker / Stent
Y N Hepatitis
Y N High Blood Pressure
Y N HIV / AIDS / ARC
Y N Hypoglycemia
Y N Kidney Problems
Y N Leukemia
Y N Liver Problems
Y N Mitral Valve Prolapse
Y N Multiple Myeloma
Y N Nervousness / Anxiety
Y N Osteoporosis
Y N Paget's Disease
Y N Psychiatric Treatment
Y N Recent Weight Loss (>10)
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Sexually Transmitted Disease
Y N Sickle Cell Disease/Trait
Y N Sinus Problems / Allergies
Y N Stomach Problems / Ulcers
Y N Stroke
Y N Swollen Ankles
Y N Thyroid Problems
Y N Tuberculosis (TB)

HAS YOUR CARDIOLOGIST, SURGEON, OR OTHER DOCTOR EVER TOLD YOU TO TAKE PREMED BEFORE ANY DENTAL TREATMENT? YES NO IF YES, WHAT MEDICATION? _____

PLEASE LIST ANY ADDITIONAL MEDICAL CONDITIONS: _____

_____

_____

PATIENT'S SIGNATURE (or Responsible Party) **DATE**

COSMETIC AND RESTORATIVE FAMILY DENTISTRY

BISPHOSPHONATES

DO YOU CURRENTLY TAKE, OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS IN THE PAST FOR THE TREATMENT OF:

OSTEOPOROSIS, MALIGNANT CANCER, OR PAGET'S DISEASE?

BRAND NAME	GENERIC FORM	YES	NO
Fosamax	Alendronate	_____	_____
Boniva	Ibandronate	_____	_____
Didronel	Etidronate	_____	_____
Skelid	Tiludronate	_____	_____
Actonel	Risedronate	_____	_____
Aredia	Pamidronate	_____	_____
Zometa, Reclast	Zoledronate	_____	_____
Benefos	Clodronate	_____	_____
Prolia/Xgeva	Denosumab	_____	_____
Atelvia	Risedromate	_____	_____
Forteo	Teriparatide	_____	_____

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

_____ _____

PATIENT'S SIGNATURE (or Responsible Party) **DATE**

COSMETIC AND RESTORATIVE FAMILY DENTISTRY

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, 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 full 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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. We DO NOT verify insurance benefits; therefore, it is the full responsibility of the patient to know and understand their individual insurance benefits, waiting periods, and all exclusions or limitations.

In consideration for the professional services rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are performed, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

I UNDERSTAND THAT MY CO-PAYMENT IS AN "ESTIMATE" ONLY AND THAT THERE IS NO WAY OF KNOWING EXACTLY WHAT MY INSURANCE COMPANY WILL PAY. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY UNPAID BALANCE, REGARDLESS OF ANY INSURANCE I MAY OR MAY NOT HAVE.

_____ _____

PATIENT'S SIGNATURE (or Responsible Party) **DATE**

*An interest rate may be charged at the discretion of the office or accountant.

COSMETIC AND RESTORATIVE FAMILY DENTISTRY

2900 Hwy 80 East
Haughton, LA 71037
(318) 949-1771

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Cosmetic and Restorative Family Dentistry's Notice of Privacy Practices, which has an effective date of April 14, 2003, and which describes how my health may be used and disclosed. I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

We at Cosmetic and Restorative Family Dentistry take your dental confidentiality very seriously. We will not and cannot release information without your written authorization. This authorization form, when completed and signed by you, allows our staff members to speak only with an individual or individuals you designate in the event that you are not available to receive phone calls or you have an adult family member that helps coordinate your or your child's dental care.

I authorize employees of Cosmetic and Restorative Family Dentistry to speak with:

NAME:_____RELATIONSHIP: _____

Phone No: Home_____ Cell_____ Work _____

_____ Appointments _____ Account/Billing _____ Treatment Plan and Treatment Decisions

NAME:_____RELATIONSHIP: _____

Phone No: Home_____ Cell_____ Work _____

_____ Appointments _____ Account/Billing _____ Treatment Plan and Treatment Decisions

_____ I DO NOT AUTHORIZE ANYONE TO RECEIVE INFORMATION REGARDING MY DENTAL CARE.

This authorization will remain in effect unless changed by me while I am a patient of this practice. It is my responsibility to notify this practice of changes and to complete a new form. I agree that should I desire to revoke this authorization, I will give written notice.

_____ _____

PATIENT'S SIGNATURE (or Responsible Party) **DATE**

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify)