Shreveport Family Dental Care

PATIENT'S INFORMATION

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

Patient's SSN #: _____ Patient's Email Address: _____

Patient's Phone # : _____ _____ _____
(HOME) (CELL) (WORK)

Patient's Address: _____
(Street Address) (City, State, Zip)

Spouse's name: _____ Spouse's Employer: _____

How did you hear about our office? _____

Emergency Contact's Name & Relationship to patient: _____

Emergency Contact's Phone # : _____ _____ _____
(HOME) (CELL) (WORK)

DENTAL INSURANCE INFORMATION

Insured's Name & Relationship to patient: _____

Insured's Employer: _____ Insured's date of birth: _____

Insured's SSN# : _____ Group # : _____ Policy ID # : _____

Insurance Company _____ Phone # : _____

Insurance Company's Address: _____
Street Address) (City, State, Zip)

RESPONSIBLE PARTY INFORMATION

Responsible Party's Name & Relationship to patient: _____ _____

Responsible Party's SSN #: _____ ___ ___ Responsible Party's Birthdate: _____

Responsible Party's Phone # : _____ _____ _____
(HOME) (CELL) (WORK)

Responsible Party's Address: _____
(Street Address) (City, State, Zip)

I authorize the staff of Shreveport Family Dental Care to perform any necessary services needed during diagnosis and treatment. I also authorize Shreveport Family Dental Care 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.

Signature:_____ **Date:** _____
(Patient or Responsible Party)

Medical History

Medical Doctor(s): _____ Phone: _____

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

_____

Allergic to: ___ Latex ___ Codeine ___ Penicillin ___ Dental anesthetics (list below)

___ Other (Please list): _____

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, back pain or neck pain? **Y / N** How often? _____ Severity? _____

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 Diabetes
Y N Emphysema
Y N Fainting/ Seizures/ Epilepsy
Y N Glaucoma
Y N Heart attack/stroke
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery/ Pacemaker
Y N Hepatitis
Y N High Blood Pressure
Y N HIV / AIDS / ARC
Y N Hypoglycemia
Y N Jaw pain
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
Y N Sinus Problems/ Allergies
Y N Stomach Problems/Ulcers
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

PLEASE LIST ANY ADDITIONAL MEDICAL CONDITIONS:

_____

_____

For Office Use Only: Entered in the computer by (initials): _____ *Date:* _____

Shreveport Family Dental Care

ACKNOWLEDGEMENT/AUTHORIZATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

The personnel at Shreveport/Bossier Family Dental Care 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 our phone calls or you have an adult family members that helps coordinate your dental care.

I authorize employees of Shreveport /Bossier Family Dental Care to speak with:

NAME_____ PHONE NUMBER _____

NAME_____ PHONE NUMBER _____

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

_____ _____

Patient's Signature (or responsible party) Date

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OFFICE USE ONLY

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

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

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	_____	_____

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**

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 cash 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.

In consideration for the professional services rendered to be 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 rendered, 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.

_____ _____

Signature of Patient, parent or guardian Date

Relationship to Patient_____

(Rev. 4/10)

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