West Louisiana Dental Center

NEW PATIENT FORMS

PERSONAL INFORMATION

NAME: ______________________ SOCIAL SEC.# ____________________ BIRTHDAY: ______________

Nickname: _________________________ ( ) Male ( ) Female ( ) Single ( ) Married

Address: __________________________________ City/State/Zip: ____________________________

Home Phone: ____________________________ Cell Phone: ___________________________________

Who may we thank for referring you to our office? _______________________________________

INSURANCE (Policy Holder's Information)

#1

Name: _________________________ Employer: ______________________ Rank: _____________

Insurance Company: ____________________________ Group# ______________________

Social Sec#: ___________________ Birthday: _______________ Phone#: _________________________

#2

Name: _________________________ Employer: ______________________ Rank: _____________

Insurance Company: ____________________________ Group# ______________________

Social Sec#: ___________________ Birthday: _______________ Phone#: _________________________

Responsible Party

Name: _________________________ Relation to patient: __________________________________

Birthday: _________________________ Social Sec#: ______________________________________

It is understood that West Louisiana Dental Center will not treat a person under the age of 18 without the parent or Guardian present in the office during the entire treatment. This includes cleanings and orthodontic care. An older Sibling will not substitute unless they are the legal guardian.

Signature of Patient/Parent/Guardian: ____

AUTHORIZATION AND RELEASE

If you child is a minor, it is necessary for permission to be obtained from the parent or legal guardian. The signature affixed below authorizes examination and treatment as necessary for this patient from the office of West Louisiana Dental Center, and further, the use of whatever procedure the doctor may deem necessary during the performance of any dental service.

Signature of Patient/Parent/Guardian: _______________________________ **Date:** ______________

Medical History

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionaire and there may be additional questions concerning your health.

1 Chief dental complaint? ______

2 Are you in good health? ______ YES NO

3 Has their been any changes in your general health within the past year? ______ YES NO

4 Are you now under the care of a physician? ______ YES NO
(If so what is your condition?) ______

5 The name and address of your physician? ______

6 Do you have or have you had any of the following diseases or problems? ______ YES NO
- a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? ______ YES NO
- b. Cardiovascular disease, heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, anteriosclerosis, stroke? ______ YES NO
  - 1 Do you have chest pain upper exertion? ______ YES NO
  - 2 Are you ever short of breath after mild exercise or when lying down? ______ YES NO
  - 3 Do your ankles swell? ______ YES NO
  - 4 Do you have inborn heart defects? ______ YES NO
  - 5 Do you have cardiac pacemaker? ______ YES NO
- c. Allergy? ______ YES NO
- d. Sinus trouble? ______ YES NO
- e. Asthma or hay fever? ______ YES NO
- f. Fainting spells or seizures? ______ YES NO
- g. Diabetes? ______ YES NO
- h. Hepatitis, jaundice, or liver disease? ______ YES NO
- i. AIDS or HIV infection? ______ YES NO
- j. Thyroid problems? ______ YES NO
- k. Respiratory problems, emphysema, bronchitis, etc.? ______ YES NO
- l. Arthritis or painful swollen joints? ______ YES NO
- m. Kidney trouble? ______ YES NO
- n. Tuberculosis? ______ YES NO
- o. Low blood pressure? ______ YES NO
- p. Epilepsy or other neurological disease? ______ YES NO
- q. Problems with mental health? ______ YES NO
- r. Cancer? ______ YES NO
- s. Problems of the immune system? ______ YES NO

7 Have you had abnormal bleeding? ______ YES NO

8 Do you have any blood disorder such as anemia? ______ YES NO

9 Have you ever had any treatment for a tumor or growth? ______ YES NO

10 Are you allergic or have you had a reaction to:
- a. Local anesthetics? ______ YES NO
- b. Penicillin or other antibiotics? ______ YES NO
- c. Sulfa drugs? ______ YES NO
- d. Barbiturates, sedatives, or sleeping pills? ______ YES NO
- e. Aspirin? ______ YES NO
- f. Iodine? ______ YES NO
- g. Codeine or other narcotics? ______ YES NO
- h. Gluten Allergy? ______ YES NO
- i. Peanut Allergy? ______ YES NO

11 Have you had any serious trouble associated with any previous dental treatment? YES NO
If so, explain? ______

12 Are you wearing removable dental appliances? ______ YES NO

13 Do you currently use tobacco of any type? ______ YES NO
If so, which? ______

14 Have you ever used alcoholic beverage? ______ YES NO

Women:

14 Are you pregnant? ______ YES NO

15 Are you nursing? ______ YES NO

16 Are you taking birth control pills? ______ YES NO

17 Do you have any disease, condition, or problems not listed above that you think we should know about? ______ YES NO
If so, explain? ______

Medical History (continued)

Current Physician Name/Number: ______________________________

Current Pharmacy Name/Number: ______________________________

CURRENT/PAST MEDICATIONS

Name:	Dose:	Frequency	Starting	Ending	Physician	Purpose

SURGICAL PROCEDURES

Date	Procedure	Physician	Hospital	Notes

Important Insurance Information

- We are a provider for United Concordia, Delta Dental, and Metlife Insurance companies. Patients with dental insurance that we are not a participating provider for, should remember that professional services are rendered and charged to the patient, not the insurance company. We will file a claim as a courtesy to the patient (maximum of (3) times. However, you the patient are responsible for the entire balance in the event your insurance company does not pay our charges. Our charges are "Usual and Customary" for the geographical area. Again you are responsible for payment regardless of your insurnace company's arbitray determination of "Usual and Customary" rates. If you do not know if we are participating in your insurance's network please ask.

- We DO NOT offer in-office financing, all fees are due at the time of service. If you need financial assistance please see billing and information and applications are available for Springstone Financial.

- ALL PATIENTS WITH INSURANCE (regardless if we are provider), a treatment plan only shows an estimate of what your insurance will pay. THIS IS ONLY A ESTIMATE, it is based on the information we have on your insurance company at the time of service. You insurance company reserves the right to down grade or choose alternative treatment at any time. In the event all or any part of your treatment is not paid as estimated the remaining amount will be the patient's responsibility.

FINANCIAL POLICY

We are commited to providing you with the best possible dental care. Payment is due at the time services are rendered. Extended payments are available before services are rendered upon special request, with approved credit. We accept payment of cash, check, and all major credit cards.

Accounts outstanding more than 30 days from treatment date will bear interest at 1 1/2% per month or 18% per annum. Orthodontic accounts are excluded from interest.

If you have dental insurance, we will accept assignment of benefits from your insurance company. In this situation any portion not paid by your insurance compay will be your responsibility. Any under - or overpayment by your insurance company will be reflected on your account accordingly.

NOTE: For ACTIVE Duty Military, your commander will be notified if you fail to pay your account. Returned checks will be subject to a $40.00 NSF Charge. We DO NOT redeposit checks. Please check one of the following options:

☐ CASH PAYMENT
You pay with cash, check or credit card at the time of visit.

☐ INSURANCE
You pay your portion at the time of each visit, and we file the rest to your insurance.

☐ UNTIED CONCORDIA, DELTA DENTAL, METLIFE
Co-payment is due on the date of service

☐ PAYMENT PLAN
Apply at billing or we have brochures for SPRINGSTONE FINANCIAL

I hereby authorize West Louisiana Dental Center to file dental claims on my behalf and to release all information necessary to secure payment.

I have read the above information and understand my financial responsibility. I am aware that a $ 40 CHARGE wil be applied to all appointments cancelled without a 24 hour notice.

Signature of Patient/Parent/Guardian: ______________________ **Date:** ____________

Relationship to patient: ______________________

PHOTOGRAPHIC RELEASE

In our office we sometimes like to photograph our patients for aid in determining their problems and to help come up with the perfect treatment. This is also a great way to show you the success of the treatment.

We are very proud of the work we have done and only use our own patients in our maketing and advertising. We may use these photos in one of our "Smile" books, our website, www.westladental.com or other office use.

AUTHORIZATION AND RELEASE

I ____ , hereby authorize West Louisiana Dental Center to take photographs, slides, and/or videos of my face, jaws, teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in demonstrations, advertising (including website publication, newspapers, phone books, and television). I further understand that if the photographs slides, and/or videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature of Patient/Parent/Guardian: ______________________________ **Date:** ____________