

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

1.) Chief dental complaint? _____

2.) Are you currently being treated by a physician? For what? _____

3.) Has there been any changes in your general health within the past year? _____
 if so explain? _____

4.) Have you ever received counseling for excessive use of alcohol and/or prescription drugs? _____
 if so explain? _____

6.) Have you had any serious trouble associated with any previous dental treatment? _____
 if so explain? _____

Do any of the below conditions apply to you?(Please check yes or no)

	YES	NO
High Blood Pressure/Hypertension		
Low Blood Pressure		
Heart Murmur		
Rheumatic Fever		
Mitral Valve Prolapse(MVP)		
Angina Pectoris/Chest Pain		
Heart Attack		
Prosthetic(artificial Heart Valve)		
Irregular/Rapid heart rate		
Pacemaker/Implanted defibrillator		
Heart Disease		
Heart or Bypass Surgery		
Tobacco		
Stroke		
Emphysema		
Asthma		
Diabetes (Type)		
Thyroid Disease/Goiter		
Liver Disease		
Hepatitis (Type)		
Blood Transfusion		
Renal Dialysis		
Aspirin Allergy		
Peanut Allergy		
Latex Allergy		
Penicillin or any Antibiotic Allergy		
Sulfa Drug Allergy		

	YES	NO
Iodine Allergy		
Local Anesthetics Allergy		
Gluten Allergy		
Codine or other Narcotic Allergy		
Barbiturates, Sedative Allergy		
Anemia		
Jaundice/liver Disease		
Bleeding Disorder/Hemophilia		
Kidney Disease		
Organ Transplant		
Cancer(Type)		
Chemotherapy		
Radiation Therapy		
Epilepsy/Seizure		
Stomach Ulcer		
Colitis/Intestinal Problems		
Osteoarthritis		
Rheumatoid Arthritis/Lupus		
Artificial Joints/Screws		
Sexually Transmitted Disease(STD)		
AIDS/HIV		
Tuberculosis(TB)		
Psychiatric Treatment		
Alcohol/Substance Abuse		
Pregnant/Nursing		
Other Specify		

Any other Allergies?: _____

Other Medical Concerns: _____

Important Insurance Information

- * We are a provider for United Concordia, CIGNA, 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 insurance company's arbitrary 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 committed 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 company 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, CIGNA, METLIFE
Co-payment is due on the date of service

PAYMENT PLAN
Apply at billing or we have brochures for LENDING PLAN

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 will 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 marketing and advertising. We may use these photos in one of our "Smile" books, our website, www.westlidental.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: _____