FONTENOT FAMILY DENTISTRY

200 Hector Connely Rd. Suite 102 – Carencro, LA 70520 – (337)-565-2580 – www.carencrodentist.com

ABOUT YOU

Patient's Name: _____ I prefer to be called _____ ☐Male ☐Female

SSN: _____ DOB: _____ Age: _____ E-Mail: _____

Address: _____ City_____ State_____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How did you find out about us?

Mailer Yellow Pages Banner Valpak Facebook Website

Internet, if So what did you Search?_____

Personal Referral, Who? _____

Other _____

PRIMARY INSURANCE

Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

Relationship to Patient: _____

Insurance Co.: _____

Phone Number: _____

Group #: _____

Employer: _____

Occupation: _____

SECONDARY INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber: _____

Subscriber's Date Of Birth: _____

Subscriber's SSN: _____

Relationship to Patient: _____

Insurance Co.: _____

Phone Number: _____

Group #: _____

Employer: _____

DENTAL HISTORY

Reason for Visit: _____

Reason you left last dentist _____

Date of Last Dental Visit: _____

What DON'T you like about your smile_____

Current Pain in Mouth and Teeth:

☐None ☐Low ☐Mod ☐High

I think my present state of dental health:

☐Poor ☐Fair ☐Good ☐Excellent

Opinion of Appearance of My Teeth:

☐Very Satisfied ☐Satisfied ☐Dissatisfied

Fear Level of Dentist:

☐None ☐Low ☐Mod ☐High

Please Check Those That Apply:

☐Head or Neck Injuries

☐Sensitive to ☐Hot ☐Cold

☐Grind or Clinch Teeth

☐Clicking or Popping Jaw

☐Dry Mouth

☐Difficulty Chewing

☐Orthodontic Treatment

☐Stained Teeth

☐Loose Teeth

☐Broken Teeth of Fillings

☐Bleeding, Swollen, or Tender Gums

☐Other (Please Clarify):

_____

_____

_____

_____

_____

HEALTH HISTORY

Physician's Name_____ Number: _____Date of Last Visit: _____

Emergency Contact_____ Number: _____

Have you been hospitalized or needed emergency care during the past 2 years? _____

Please Check Those That Apply:

☐ Allergies/Hay Fever	☐ Diabetes	☐ Heart Surgery*	☐ Rheumatic Fever
☐ Anemia	☐ Epilepsy or Seizures	☐ Hepatitis	☐ Rheumatism
☐ Angina	☐ Excessive Thirst	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Arthritis	☐ Fainting or Dizziness	☐ HIV*/AIDS	☐ Sinus Problems
☐ Artificial Joints*	☐ Fever Blisters/Cold Sores	☐ Kidney Problems	☐ Stroke
☐ Artificial Heart Valves*	☐ Frequent Cough	☐ Liver Problems	☐ Surgical Shunt*
☐ Asthma	☐ Glaucoma	☐ Mental Disorders	☐ Thyroid Problems
☐ Breathing Problems	☐ Heart Disorder (Congenital)*	☐ Mitral Valve Prolapse*	☐ Tuberculosis
☐ Cancer	☐ Heart Infection*	☐ Osteoporosis	☐ Ulcers
☐ Chemical Dependency	☐ Heart Murmur*	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Heart Pace Maker*	☐ Respiratory Problems	☐ Yellow Jaundice

*This condition may require antibiotic premedication for certain dental procedures.

☐ OTHER (PLEASE CLARIFY): _____

_____

ARE YOU:			WOMEN:		
Presently being treated for any illness	☐Y	☐N	Pregnant	☐Y	☐N
Taking any medications regularly	☐Y	☐N	Taking Birth Control	☐Y	☐N
Aware of any recent weight change	☐Y	☐N	In Menopause	☐Y	☐N
Often thirsty or urinating	☐Y	☐N	Past Menopause	☐Y	☐N
Subject to frequent headaches	☐Y	☐N			
Tobacco User	☐Y	☐N			
Often unhappy and depressed	☐Y	☐N			

ALLERGIES

☐Aspirin ☐Codeine ☐Latex ☐Acetaminophen ☐Ibuprofen ☐Erythromycin

☐Penicillin ☐Sulfa ☐Iodine ☐Local Anesthetics ☐Other: _____

MEDICATIONS (including herbal):

Name	Dose	Reason

X _____ Date _____
Signature of patient, parent or guardian

Payment, Financial, and Insurance Information

We appreciate the opportunity to serve you. It is our intention to provide you with the finest care possible, while ensuring that you fully understand procedures, treatment, and payment expectations.

We ask that all payments or co-payments be made at the time of service.

For your convenience, we accept check, cash, Visa, MasterCard, Discover, and Care Credit.

Insurance: Our office is happy to help you process your insurance. We will complete our portion of the claim form and mail it promptly at no charge. To avoid confusion, it should be understood that insurance billing is an elective service provided to our patients. Difficulty obtaining insurance payment may occur, and **insurance payments CANNOT be guaranteed**. **Patient is solely and ultimately responsible for payment.**

If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information _____ (*please initial*).

Scheduling Information

Except in emergency situations, you can expect us to be on time for you, and we will appreciate the same courtesy.

Your appointment time is tailored for you. If the need arises to reschedule your appointment, please provide us at least **2 business days notice.**

Without adequate notification, we will not be able to give your reserved time to another patient in need of dental care. There is a **$25.00 broken appointment fee** for every hour of the scheduled appointment. This fee covers the room preparation charge and the idle time of the Doctor, hygienist, and dental assistant who were on duty to provide your personalized care.

If your schedule does not permit you to plan in advance, we might suggest placing you on our list of patients to call on a short notice basis.

If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information _____(*please initial*).

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our privacy officer, Ian M Fontenot, DDS.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature below I acknowledge receipt of the Notice of Privacy Practices.

X _____ Date _____
Signature of patient, parent or guardian

Miscellaneous

General Consent of Treatment

I agree and consent to a dental examination by a Dentist at Fontenot Family Dentistry. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as the results of any procedures or dental treatments performed.

Release of Information

I authorize Fontenot Family Dentistry to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits: I authorize and request my insurance company to pay my benefits directly to Fontenot Family Dentistry.

Photography Release

I authorize Fontenot Family Dentistry to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize them to show these photographs to other patients to better explain their treatment options. I also understand that these photographs may be used as education materials. I waive my right to any financial reward from the use of these photographs.

I understand and will comply with office **Appointment Policy.**
I understand and will comply with the office **Financial Policy.**
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me and shown to other patients or dental / medical colleagues.

X _____ Date _____ Signature of patient, parent or guardian