the DENTAL SUITE

LINDI PERKINS, DDS

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as compfetely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date ___________ home phone _______________ cell phone _______________

Name ______________________________ SS/HIC/Patient ID _______________

Address ______________________________ Email ___________________________

City ___________________________ State ____________ Zip ________________

Sex _____ M _____ F Age ______ Birthdate _________

Marital Status _____ Married _____ Divorced _____ Single _____ Widowed _____ Seperated

Occupation _____________________ Employer/School ________________________

Employer Address ____

Emergency Contact ______________ Phone _____________ Relationship ___________

Who referred you to us? ____

DENTAL INSURANCE INFORMATION

Person Responsible to Account _______________________________________

Relation to Patient _______________ Birthdate ________ Soc. Sec. # ______________

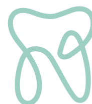
Address (if diff. from patient) _________________________ Phone _________________

City ___________________________ State ____________ Zip ________________

Insurance Company ____

Contract # _______________ Group # ______________ Subscriber # ______________

4325 LOVELAND ST
METAIRIE, LA 70006
DENTISTMETAIRIE.COM



office (504) 888 9333
fax (504) 883 5941
INFO@DENTISTMETAIRIE.COM

Health History

Name ____________________ Date ____________________

What is the reason for your visit today? ____________________

Are you satisfied with your teeth's appearance? .... No Yes

Are you interested in Professional Whitening of your teeth? .... No Yes

Are you interested in straightening of your teeth? .... No Yes

Are you interested in bad breath management techniques? .... No Yes

Date of: Last Dental Visit __________ Last Dental Cleaning __________ Last Full Mouth X-Rays __________

What was done at your last dental visit ____________________

How often do you have dental examinations __________ Previous Dentist's Name ____________________

Telephone Address __________ ____________________

How often do you brush your teeth __________ Do you use electric toothbrush .... No Yes

How often do you floss? __________ What other dental aids do you use (toothpick, etc.) __________

Do you have any dental problems now? .... No Yes

If yes, please describe ____________________

Do you feel nervous about having dental treatment? .... No Yes If

If yes, what is your biggest concern? ____________________

Have you ever had an upsetting dental experience .... No Yes

If yes, please describe ____________________

Is there anything else about having dental treatment that you would like us to know? ____________________

What are your hobbies or special interests (sports etc.) ____________________

Are any of your teeth sensitive to:				**Have you ever had:**		
• Hot or cold?	No	Yes		• Orthodontic treatment?	No	Yes
• Sweets?	No	Yes		• Oral Surgery?	No	Yes
• Biting or chewing?	No	Yes		• Periodontal (gum) treatment	No	Yes
• Have you noticed any mouth odors or bad tastes	No	Yes		• A bite plate or mouth guard	No	Yes
• Do you frequently get cold sores, blisters or any other oral lesions?	No	Yes		• A serious injury to the mouth or head?	No	Yes
• Do your gums bleed or hurt?	No	Yes		**Have you experienced:**		
• Have your parents experienced gum disease or tooth loss?	No	Yes		• Headaches, neckaches or shoulder aches	No Yes	
•Have you noticed any loose teeth or change in your bite	No	Yes		• Sore muscles (neck, shoulders, side of face)	No Yes	

● Does food tend to become caught in between your teeth	No	Yes		● Pain (side of face, joint, ear?)	No	Yes
Do you :				● Clicking or popping of the jaw	No	Yes
● Clench or grind teeth while awake or asleep	No	Yes		● Difficulty in chewing on either side of the mouth?	No	Yes
● Bite your lips or cheeks regularly	No	Yes		● Difficulty in opening or closing the mouth?	No	Yes
● Mouth breathe while awake or asleep?	No	Yes		● Have tired jaws especially in the morning?	No	Yes

Date of last health care exam: ________________ What was this exam for? ________________________________

Have you been hospitalized in the last 5 years? .... No Yes

If yes, reason: ____

Are you currently receiving care?......................No Yes ▶ If yes, nature of care: ____________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart (Surgery, Disease, Attack)	No	Yes		Heart Murmur	No	Yes
Latex Sensitivity	No	Yes		Anemia	No	Yes
Diabetes	No	Yes		Previous Biopsies	No	Yes
Epilepsy	No	Yes		Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form (specify)	No	Yes		Other Infections	No	Yes
Rheumatic Fever	No	Yes		Recurrent Illnesses	No	Yes
Asthma	No	Yes		Psychosis	No	Yes
HIV Positive or AIDS Related Complex	No	Yes		Liver Disease (including Jaundice)	No	Yes
Mitral valve prolapse	No	Yes		Unintentional Weight Loss/Gain	No	Yes
Abnormal Heart Condition	No	Yes		Glaucoma	No	Yes
Kidney Disease	No	Yes		Abnormal Bleeding from a cut	No	Yes
Joint Replacement	No	Yes		Sore/Enlarged Lymph Nodes	No	Yes
Venereal Disease	No	Yes		Emphysema or other Respiratory Illnesses	No	Yes

Women: ● Are you pregnant?__________ ● If no, are you planning a pregnancy in the near future? .... No Yes

Are you a nursing mother?......... No Yes ● Are you taking birth control pills? .... No Yes

Are you required to Pre-Medicate before dental treatment? .... No Yes

Abnormal Blood Pressure? (Please circle)...... No Yes ▶ If yes, what is it usually: S .... / D.........

Are you allergic or have you had a reaction to:

a. Local anesthetics .... No Yes

b. Penicillin or other antibiotics .... No Yes

c. Aspirin .... No Yes

d. Codeine, valium or other sedatives.. No Yes

e. Other ____

Do you smoke / chew tobacco? .,................. No Yes ▶ If so, how much do you smoke per day? __________

Please list any medications you are currently taking:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

5. ______________________ 6. ______________________

Are you taking Tagamet (Cimetidine)? .... No Yes ▶ If yes, how often? ______________

Do you take Antacids? .... No Yes ▶ If yes, how often? ______________

Are you taking any herbal supplements?........ No Yes ▶ If yes, which ones? ______________

Diet: Restricted Diet _______ How many meals a day _______ Food Allergies ______________

Sugar in your diet: **None** Slight **Moderate** **High**

Do you have or have you had any disease, condition or problem not listed? .... No Yes

If yes, please list ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) ______________ *Patient Signature* ______________ *Date* __________

Doctor (Print Name) ______________ *Doctor Signature* ______________ *Date* __________

Payment Policy

We will provide you with a treatment plan estimating your cost and any insurance benefits for dental care that you may need. Our practice requests payment at the conclusion of each visit. For patients with insurance, the *estimated* co-payment is requested at this time. As a courtesy, we will be pleased to submit insurance claims on our patient's behalf. Please note that any remaining balance, after insurance payment or denial, is the patient's responsibility to pay.

For treatment provided, our practice accepts cash, personal checks, and major credit cards, such as American Express, Visa, MasterCard, and Discover.

If you need to make financial arrangements for your portion, please feel free to do so with our Office Manager, in advance of dental treatment. We will be happy to discuss payment plan options and customize a payment plan for you.

We respect your time and we make a sincere effort to see all our patients on time. We ask that you respect our time and call us 48 business hours in advance, if you must cancel or reschedule your appointment. We waive the fee the first time you cancel without 48 hours' notice, as we know emergencies do arise. **We charge a broken appointment fee of $100.00** the second time your appointment is cancelled with less than 48 hours' notice. The third time this occurs, we regret to charge you **$200.00 for broken appointment.** Please understand any changes in our schedule affects patients waiting to complete their dental care.

I have read and understand the practice's payment policy. Accounts not paid in a timely manner are subject to a late fee. I understand that if the terms of any payment agreement are broken, the account will immediately be turned over to a third party or collection agency.

______________________________ ______________________

Signature of patient and/or guarantor **Date**

Consent for Internet Communications

(optional - you May Refuse to Sign This Acknowledgment)

I grant my permission to The Dental Suite to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for The Dental Suite. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand The Dental Suite and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that The Dental Suite is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand The Dental Suite is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use The Dental Suite web site with my ID and password. I also agree to immediately notify The Dental Suite of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand The Dental Suite will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that The Dental Suite has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand The Dental Suite will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand The Dental Suite CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for The Dental Suite and grant The Dental Suite permission to securely upload my patient information to the web site.

______________________________ Date: __________ e-mail ________________ Relationship to Patient: __________

Signature of patient and/or guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

you May Refuse to Sign This Acknowledgment

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

Please Print Name

Signature

Date

FOR 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)