Patient Information

Patient Name: ______________________________ Date: __________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other Driver License/ID #: __________

Social Security #: __________________ Birth Date (DOB): __________________

Phone (Home): __________ (Work): __________ Cell: __________

E-mail ______________________________

Mailing address: ______________________________
Street/PO Box Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: __________ **Reason for this visit:** __________________

Have you ever had any of the following? Please circle those that apply:

Atrial Fibrillation Artificial Joints Artificial Heart Valve Acid Reflux Cancer Diabetes

Epilepsy Bleeding Disorder Restless Leg Syndrome Heart Disease Hepatitis Stroke

High Blood Pressure Mental Disorders Nervous Disorders Pregnancy Due Date: __________

Radiation Treatment Heart Attack Allergies: ______________________________

Are you a Smoker: YES or NO

- **List ALL current medications** ______________________________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ______________________________

- Have you been admitted to a hospital or needed emergency care during the past year? ☐ Yes ☐ No
  If yes, please explain: ______________________________

☐ **Are you currently taking or have you ever taken any treatment for osteoporosis? YES OR NO**
Boniva Fosamax Actonel Zometa Reclast

- Do you have a primary care physician? ☐ Yes ☐ No
- Name of Physician: ______________________________ Phone: __________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: __________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐Another doctor
☐ Google ☐ Facebook ☐ Passer by ☐ Website ☐ Other __________
Name of person or office referring you to our practice: __________

Emergency Contact Information

Name: ______________________________

☐ Male ☐ Female ☐ Spouse ☐ Parent ☐ Child ☐ Other ____________

Phone (Home): ____________ (Work): ____________ (Mobile): ____________

Employment Information

Employer Name: ______________________ Employer Phone #:=: ____________

Address: ______________________________
Street City State Zip Code

Insurance Information

Primary
Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who do not carry dental insurance (or insurance eligibility cannot be verified before the appointment) must pay in full for all services rendered at the time services are performed. Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and that they are personally responsible for payment of all dental services. This office will assist in making collections from insurance companies by submitting the appropriate dental claims. However, patients are responsible for the entire amount not reimbursed by the insurance companies. Patient deductibles, co-insurance and estimated non-reimbursable amount must be paid in full at the time the services are provided. Pre-estimates for treatment provided by insurance companies do not represent a guarantee for reimbursement. A service charge of 1% per month (12% annually) on the unpaid balances will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for my dental care can only be extended for a period of six months from the date listed on the treatment plan. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to contact me (via phone or e-mail) to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

______________________ Date: ________ Relationship to Patient: ____________
Signature of patient, parent or guardian

______________________ Date: ________ Relationship to Patient: ____________
Signature of guarantor of payment/responsible party

REV 8-2022

Consent for Release of Protected Health Information

Patient Information: (person whose information will be released)

Name______________________________ Date of Birth____/____/____SSN______________

Address____

Practice name ____Dental Care Group____ Doctor's name ____Dr. Jordan / Dr. Causey____________

I understand that this authorization will allow Dental Care Group and its affiliates to use or disclose the protected health information described below:

PLEASE CHECK ONE BOX:

- ☐ All health care information
- ☐ Other:

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____

I request and authorize the above listed doctor and practice to release my health care information to:

Name______________________________________ Date of Birth _____/______/________

Address____

E-mail______________________________________ Phone Number (_____)______-________

Relationship (**circle one**): Spouse Parent Child Sibling Friend Agent/Broker Organization POA Doctor

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

____

Signature of patient or patient's authorized representative   Date Signed

____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

STOP BANG

Screening for: OBSTRUCTIVE SLEEP APNEA

Answer the following questions to find out if you are at risk for Obstructive Sleep apnea.

STOP

S (snore)	Have you been told that you snore?	YES / NO
T (tired)	Are you often tired during the day?	YES / NO
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	YES / NO
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	YES / NO

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BMI)	Is your body mass index greater than 28?	YES / NO
A (age)	Are you 50 years old or older?	YES / NO
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches.	YES / NO
G (gender)	Are you a male?	YES / NO

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

DENTAL CARE GROUP

CANCELLATION POLICY

It is our goal to ensure that we provide you with the best dental care possible and we offer you a pleasant experience in our office. We understand that you have a busy schedule and we respect your time. Therefore, it is our office policy to never double book patients, so the time set aside for your appointment is dedicated to you only.

In return, we ask that you respect our time, by confirming your appointment the day before (at least 24 hours in advance). You may do so by calling the office at 225-673-1557, sending a text to the office cell number 225-329-9319 or emailing contact@dentalcaregroupla.com.

If you cancel or reschedule your appointment less than 24 hours from the appointment time or don't show up for your appointment, you will be charged a fee for each missed appointment ($60-80 per each appointment).If you are more than 15 late for your appointment , please understand that we won't have enough time to complete all the planned procedures and we will consider that a "cancelled appointment".

Thank you for giving us the opportunity to take care or your dental needs.

Sign:____