

Welcome to our office

PATIENT INFORMATION

Date _____ Daytime Phone _____

Patient's Name _____

Sex: M F Minor Single Married Divorced Widowed

Address _____ Apt. # _____

City/State/Zip _____

Home Phone _____ Date of Birth _____ SS# _____

Patient Employed by _____ Occupation _____

Business Address _____

City/State/Zip _____ Work Phone _____

RESPONSIBLE PARTY

(If different from Patient)

Person Responsible for Account _____

Address _____ Apt. # _____

City/State/Zip _____

Home Phone _____ Relation to Patient _____

SS# _____ Date of Birth _____

Employer _____ Work Phone _____

Business Address _____

INSURANCE INFORMATION

Is patient covered by Dental Ins.? YES/NO Name of Ins. Co. _____

Policy # _____ Group # _____

Name of Insured Person _____

If different from Responsible Party, please provide:

Insured's Date of Birth _____ SS# _____

Name of Employer _____ Work Phone _____

Address _____ Apt. # _____

HOW DID YOU HEAR ABOUT OUR OFFICE _____

PLEASE CHECK (✓) IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor Health | <input type="checkbox"/> Facial x-ray treatment | <input type="checkbox"/> Nose obstruction |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent swollen ankles | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Recent cough/cold |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Recent illness |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone or ACTH | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral valve prolapse | |

ALLERGIES: *(please circle all that apply)* Penicillin Sulfa Codeine Aspirin
Local Anesthetic Barbiturates (sleeping pills) Other drugs _____

Medical Physician's Name _____

Are you pregnant? NO YES

Are you now under the care of a physician? NO YES

Are you taking medicine of any kind? NO YES If so, list _____

Do you have any medical problems we should know about? NO YES

Reason for today's visit? _____

Why did you leave your last Dentist? _____

What did you like most about any Dentist you've seen? _____

If you could change one thing about your smile, what would it be? _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits payable to me for services rendered. I authorize the use of this signature on all insurance claims and I give permission for the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I agree to pay all cost of collection should this account become past due.

DENTAL Insurance Verification Form /Outline Of Benefits

Insurance Information:

Date Called: _____ You're Name: _____
Policy Holders Name: _____ D.O.B. _____
Policy Holders SS#: _____ Group # _____
Patients Name: _____ D.O.B _____
Insurance Company: _____
Policy Holders Employer / Group Name: _____
Ins. Co. Phone # _____ Spoke to: _____
Claims Address: _____

YEARLY MAXIMUM \$ _____

Benefits:

***Breakdown:**

*Effective Date: _____ P- _____
*Employee Only or Family coverage B- _____ * _____
*Calendar Year or Fiscal Year M- _____ * _____
*In Network or Out of Network *** Deductibles:**
*Missing Tooth Clause? YES or NO Individual: \$ _____ met \$ _____
*Replacement Clause? YES or NO Family: \$ _____ met \$ _____
*Waiting Periods? YES or NO (If Yes) explain _____

Frequency Limits:

*Prophy, Exams Etc. - _____ *Bitewings: _____
*FMX Frequency - _____ *History - _____
Full Mouth Debridement? _____ SC/RP _____
FL2 ? _____% Age Limits ? _____ Sealants ? _____% Age Limits ? _____

****Ask what where (%) Perio. and Endo. fall and note next to that coverage benefit ****

Thomas E. Drake, D.D.S.
Family Dentistry

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PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dated, phone/fax numbers, email addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To our health care providers (i.e., your physician, oral surgeon, etc.) in connection with our rendering dental treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing, and accrediting bodies (i.e., the Board of Dentistry, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment;
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;

- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us., and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at us office address. Thank you.