PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Birthdate: _____ Soc Sec: _____ Drivers Lic: _____

Sex: **Male / Female** Marital Status: (circle one) **Married Single Divorced Separated Widowed**

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

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

E-mail address: _____ I would like to receive correspondence via e-mail **YES / NO**

Whom may we thank for referring you? _____

Parent/Guardian Information

First Name: _____ Last Name: _____ Relationship to Patient:_____

Birthdate: _____ Soc Sec: _____ Drivers Lic: _____

Is address same as patient? **YES / NO** (If no, please complete the information below)

Address: _____ Apartment#: _____

City: _____ State: _____ Zip: _____

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

Patient Insurance Information

Name of policy holder: _____ Relation to policy holder: (circle) **self spouse child other**

Policy holder Soc Sec: _____ Policy holder Birth date: _____

Employer: _____ Insurance Co: _____

Ins. Phone# _____ Ins. Address: _____

City: _____ State: _____ Zip: _____

Member/Policy#: _____ Group: _____

In case of emergency:

Name: _____ Phone# _____

Relationship to patient: _____

By signing this form, I acknowledge to the best of my ability that the information provided is accurate. I also give my permission for the patient named above to be treated by the doctors and staff of Jefferson Dental Care.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Medical History **Patient Name:** _____ **Birthdate:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	YES	NO	Explain:	
Have you ever been hospitalized or had a major operation?	YES	NO	Explain:	
Have you ever has a serious head or neck injury?	YES	NO	Explain:	
Are you taking any **medications**, pills or drugs?	YES	NO	Explain:	
Do you take, or have you taken, Phenfen or Redux?	YES	NO	Explain:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	YES	NO	Explain:	

Are you on a special diet?	Y / N	Do you use tobacco?	Y / N	Do you use controlled substances?	Y / N

Women: Are you			
Pregnant/Trying to get pregnant?	YES	NO	
Taking oral contraceptives?	YES	NO	
Nursing?	YES	NO	

Are you allergic to any of the following?

Asprin	Penicillin	Codeine	Local anesthetics	Acrylic	Metal	Latex	Sulfa drugs
Other	If yes, please explain _____					Food allergies: _____	

Do you have or have you had any of the following? (Please Circle Yes or No)

AIDS/HIV Positive	Y / N	Emphysema	Y / N	Low Blood Pressure	Y / N
Alzheimer's Disease	Y / N	Epilepsy or Seizures	Y / N	Lung Disease	Y / N
Anaphylaxis	Y / N	Excessive Bleeding	Y / N	Mitro Valve Prolapse	Y / N
Anemia	Y / N	Excessive Thirst	Y / N	Osteoporosis	Y / N
Angina	Y / N	Fainting Spells/Dizziness	Y / N	Pain in Jaw or Joints	Y / N
Arthritis/Gout	Y / N	Frequent Cough	Y / N	Parathyroid Disease	Y / N
Artificial Heart Valve	Y / N	Frequent Diarrhea	Y / N	Psychiatric Care	Y / N
Artificial Joint	Y / N	Frequent Headaches	Y / N	Radiation Treatments	Y / N
Aspergers Syndrome	Y / N	Genital Herpes	Y / N	Recent Weight Loss	Y / N
Asthma	Y / N	Glaucoma	Y / N	Renal Dialysis	Y / N
Autism	Y / N	Hay Fever	Y / N	Rheumatic Fever	Y / N
Blood Disease	Y / N	Heart Attack/Failure	Y / N	Rheumatism	Y / N
Blood Transfusion	Y / N	Heart Murmur	Y / N	Scarlet Fever	Y / N
Breathing Problem	Y / N	Heart Pacemaker	Y / N	Shingles	Y / N
Cancer	Y / N	Heart Trouble/Disease	Y / N	Sickle Cell Disease	Y / N
Cerebral Palsy	Y / N	Hemophilia	Y / N	Sinus Trouble	Y / N
Chemotherapy	Y / N	Hepatitis A	Y / N	Spina Bifida	Y / N
Chest Pains	Y / N	Hepatitis B or C	Y / N	Stomach/Intestinal Dis	Y / N
Cold Sores/Fever Blisters	Y / N	Herpes	Y / N	Stroke	Y / N
Congenital Heart Disorder	Y / N	High Blood Pressure	Y / N	Swelling of Limbs	Y / N
Convulsions	Y / N	High Cholesterol	Y / N	Thyroid Disease	Y / N
Cortisone Medicine	Y / N	Hives or Rash	Y / N	Tonsilitis	Y / N
Dementia	Y / N	Hypoglycemia	Y / N	Tuberculosis	Y / N
Diabetes	Y / N	Irregular Heartbeat	Y / N	Tumors or Growths	Y / N
Down Syndrome	Y / N	Kidney Problems	Y / N	Ulcers	Y / N
Drug Addiction	Y / N	Leukemia	Y / N	Vernereal Disease	Y / N
Easily Winded	Y / N	Liver Disease	Y / N	Yellow Jaundice	Y / N

Other: _____

Patient/Parent/Guardian Signature _____ Date: _____

Smile Analysis

NAME_____ DATE _____

Your smile affects your self-image, and can greatly influence the qualty of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable about their appearance when they do. Please answer the following questions.

Are any of your teeth yellow, stained or somewhat discolored?	YES	NO
Would you like your teeth to be whiter?	YES	NO
Do you have any gaps or spaces between your teeth?	YES	NO
When being photographed, do you smile with your lips closed instead of flashing a full smile?	YES	NO
Are you missing any teeth?	YES	NO
Do you see any defects on the surfaces of your teeth, teeth worn down, chipped or uneven?	YES	NO
Does the appearance of your smile inhibit you from laughing or smiling?	YES	NO
Do any of your teeth appear too small, short, large or long?	YES	NO
Do you have any prior dental work that appears unnatural?	YES	NO
Are your gums red, sore, puffy, bleeding or receeded?	YES	NO
Are you self-conscious about your teeth or smile?	YES	NO
Do you have a "gummy" smile (too much of your gums show when smiling)?	YES	NO
Would you like to change anything about the appearance of your teeth or smile?	YES	NO
Please rate your smile on a scale of 1-10 (1 being the worst and 10 being the best)	1 2 3 4 5 6 7 8 9 10	

Notice of Privacy Practices

I, _____, understand that, under the Health Insurance Portability &
(Patient Name)
Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment directly from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at the address below to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested instructions, but if you do agree then you are bound to abide to be such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken such action relying on this consent.

Patient Signature_____ Date_____

Parent/Guardian signature _____ Date _____

CHARLES JOUANDOT, D.D.S.
3809 JEFFERSON HWY., JEFFERSON LA 70121
T. 504 833 2211 F. 504 828 0802
WWW.JEFFERSONDENTALCARE.COM INFO@JEFFERSONDENTALCARE.COM

PATIENT NAME: _____ DATE: _____

Jefferson Dental Care (JDC) is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR PATIENT REGISTRATION PACKET BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTERCARD, DISCOVER AND CARE CREDIT**
- **JDC PROVIDES INSURANCE BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

MINORS ACCOMPANIED OR UNACCOMPANIED BY AN ADULT

The parents or guardians accompanying a minor are responsible for full payment at time of service. All non-emergency treatment of unaccompanied minors will be denied unless charges have been pre-authorized by parent or guardian prior to appointment.

INSURANCE

JDC provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. The amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any benefit period. The patient may not rely upon any information provided by JDC staff regarding his/her remaining benefits in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to JDC. However, if you are paid by the insurance company instead of JDC, then you become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will accept assignment of benefits for primary insurance only. However, we will assist our patients in the filing process with any additional insurance.

WORKER'S COMPENSATION

If you are covered by worker's compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to date of service.

DELINQUENT PAYMENTS

All payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00. JDC reserves the right to turn any delinquent account over to a collection agency with a $25.00 fee added to the account balance.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per each 30 minutes of missed appointment time. JDC also reserves the right to dismiss any patient who misses or cancels 3 appointments without giving at least 24 hours' notice. Please help us service you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ Date: _____

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