



NEW ORLEANS DENTAL CENTER MEDICAL HISTORY

Patient's Name _____ Date of Birth _____ Social Security # _____
 Address _____ City _____ State _____ Zip _____
 Home# () _____ Work# () _____ Cell# () _____
 Email Address (please print) _____ Referred by _____

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 If yes, please explain _____
 Have you been hospitalized or had a major operation? Yes No If yes, please explain _____
 Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
 Are you taking any medications, pills or drugs? Yes No If yes, please explain _____
 Do you take or have taken Phen-Fen or Redux? Yes No _____
 Are you on a special diet? Yes No _____
 Do you use tobacco? Yes No _____
 Do you use controlled substances? Yes No _____
 Do you need to take antibiotics prior to dental treatment (due to heart condition, prosthetic joint, etc)? Yes No _____
 Have you had eye surgery in the past 8 weeks? Yes No _____

Women: Are you Pregnant/Trying to get pregnant? Yes No
 Taking oral contraceptives? Yes No Nursing? Yes No

Do you like your smile? Yes No Are you nervous? Yes No

Are you allergic to any of the following? No known allergies
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Sulfa Drugs Sulfite (chemical in local anesthetic) Other If yes, please _____

Do you have, or have had any of the following?

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

Person, **NOT LIVING WITH YOU**, to notify in case of emergency:
 Name _____ Phone# _____ Relationship _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

NEW ORLEANS DENTAL CENTER – Page 2

Insurance Information:

As a **courtesy** to you and your family, our office will send claims, letters, x-rays and any other necessary information to your insurance company for reimbursement of your dental treatment. **You, however, are responsible for monitoring the use of your benefits and for remaining within your maximum covered benefit during each year of coverage.** The deductible and estimated percentage your insurance company does not cover is to be paid in full upon the date of service. According to Louisiana law, **insurance companies must respond within 30 days** of receiving a claim. If we haven't heard from your insurance company within 30 days, we will make two phone calls **FOR YOU**: one call to your insurance company to find out why they haven't paid and the second call to you, to let you know your insurance company has not paid and to get you involved at that point. **After 45 days, any remaining balance from unpaid insurance claims (for example: rejected, denied, or partial payments) will be your personal obligation.**

Scheduling Agreement:

You will love how we make appointments at New Orleans Dental Center. We have written an agreement for you to read and sign, to explain how we schedule our appointments. **This agreement will ensure that you will rarely wait to be seen at our office.** You know how when you go to a doctor's office, you sign a clipboard and then you wait indefinitely in the waiting room and nobody even cares that they are late? That's because they have scheduled multiple patients at your appointed time. **We do not double or triple book our rooms,** so when you are scheduled, that time is reserved for you and only you. Therefore, **it is important that you are on time for your appointment.** When we make your appointment, we assume that the appointment is a confirmed appointment, but as a courtesy to you, we will contact you the day before your appointment, either by phone, email or text message, as a reminder. As a result of this process, your appointment cannot be changed once it is made. However, we understand that circumstances arise that can cause patients to change their schedules. **SO, if you have to change your appointment, we will need 24-48 hours notice to do so.** As long as we have this notice, no fees will be charged to you for the schedule change, and we will be able to reschedule your appointment. If we do not have this notice, we may have to see you only on a short-term basis, as well as charge you a fee for the missed appointment. The 24-48 hour notice allows us to be able to see emergency patients on the same day and will also allow you to run your personal schedule more efficiently, as you will know when your appointment begins and when it ends and **RARELY HAVE TO WAIT!!!** Our patients love this system and we're confident that you will also. **Thank you for your cooperation and understanding.**

I have read, understand and agree to all of the above:

Patient's name (please print) _____ Relationship to patient: _____

Signature: _____ Date: _____

Notice of Privacy Practice Acknowledgement:

I acknowledge that I have received your Notice of Privacy Practices, which contains a complete description of the use and disclosures of my health information.

Patient's name (please print): _____

Relationship to patient: _____

Signature: _____ Date: _____

*****For Office Use Only*****

An effort was made to obtain a signature that the individual received a copy of the Notice of Privacy Practice, but was unable to do as documented below:

Patient's name: _____ Date: _____ Initials: _____

Reason: _____

NEW ORLEANS DENTAL CENTER – Page 3
CONSENT FOR TREATMENT AND PATIENT RESPONSIBILITY

The doctors and staff feel confident in the thorough explanations we give regarding the treatment that we recommend. We are always happy to explain anything, as many times as needed. Because every body is different, with different immune system health and unique reactions, there are risks associated with any dental treatment. These include the administration of any local or general anesthetic agent, medications to produce conscious sedation, and/or pre-medication prior to dental treatment. Some of the risks/complications are, but are not limited to, the following:

- Infection and/or swelling
- Allergic or other reactions to drugs or medicaments (such as nausea, vomiting)
- Bleeding
- Bacterial endocarditis
- Instrument breakage
- Dry socket
- Trismus (jaw pain or difficulty opening mouth)
- Paresthesia (numbness of face and/or mouth and/or tongue)—usually transient but could be permanent
- Opening between mouth and sinus or mouth and nose
- Failure of treatment to accomplish main purpose
- Loosening or additional spacing of teeth
- Changes in occlusion (biting/chewing)
- Delay or failure of healing of surgery site
- Injuries to adjacent teeth, restorations and/or hard/soft tissue
- Loss of teeth and/or bone
- Incomplete removal of tooth/root
- Swallowing or aspiration of objects
- Tooth or fragment(s) in maxillary sinus
- Breakage of root(s) and/or retained root fragment(s)
- Fracture of mandible (lower jaw) or maxilla (upper jaw)
- Jaw muscle cramps or spasms
- Increase in existing TMJ (jaw joint) dysfunction, known or unknown
- Sloughing (unanticipated loss of soft tissue and/or bone)
- Pain referred to ear/neck/head
- Death (extremely rare)

Additional oral surgery, hospitalization, and/or further treatment may be required in the event of any complication(s). Be assured that we are careful to minimize the potential for any risks associated with dental treatment.

I understand that it is my responsibility for payment of dental services provided for my dependents or me, due and payable at the time of services rendered, unless prior financial arrangements have been made, and regardless of any presumed insurance benefit. Any fees quoted are valid for six (6) months from the date of the treatment plan. **No refunds for professional services rendered will be given.**

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this form. I was given adequate opportunity to ask any questions and all questions were answered to my satisfaction. I hereby authorize the dentist and/or associates, hygienists, assistants of their choice to perform for _____ the diagnostic, surgical, orthodontic and/or dental treatment agreed upon between the doctor and the patient or parent/guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. This consent form will remain valid unless revoked by me in writing.

Patient's or Parent/Guardian's Signature

Date

Witness