

# 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.

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 \_\_\_\_\_  
 Have you ever taken Fosamax, Boniva, Actonel or any medications containing Bisphosphonates?..... 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 \_\_\_\_\_  
 Have you been told you snore?..... Yes No \_\_\_\_\_  
 Have you been diagnosed with Sleep Apnea?..... 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 about dental treatment? 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, please explain \_\_\_\_\_

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

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

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**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:** \_\_\_\_\_

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**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