

Distinctive Smiles of Baton Rouge

Patient Registration Form:

Full Name: _____

First

Middle

Last

Date of Birth: _____ Age: _____ Social Security Number: _____ - _____ - _____

Home Address: _____

City _____ State: _____ Zip Code: _____

Home # _____ Cell # _____ Work # _____

Email Address: _____

In case of emergency, notify: _____ Phone # _____

How did you hear of our practice? _____

Insurance Information

Who is responsible for this account? _____ Relationship to patient? _____

Insurance Company: _____ Policy # _____

Subscriber's Name _____ Relationship to patient: _____

Subscriber's D.O.B.: _____ Subscriber's Social Security Number _____ - _____ - _____

Assignment and Release:

I certify that I, and/or any dependant have insurance coverage with _____ Insurance company and assign directly to Dr. O'Rourke-Allen all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Signature of Patient, Parent, Guardian or Representative

Date

Printed name of Patient, Parent, Guardian or Representative

Relationship to patient



SIX MONTH SMILES®

Cosmetic Appliance System

WHAT ASPECTS OF YOUR SMILE WOULD YOU LIKE TO IMPROVE?

- | | |
|---|--|
| <input type="checkbox"/> CROWDING/CROOKED TEETH | <input type="checkbox"/> JAW JOINT PAIN |
| <input type="checkbox"/> SPACES | <input type="checkbox"/> MISSING TEETH |
| <input type="checkbox"/> TOOTH SHAPE | <input type="checkbox"/> DARK TEETH |
| <input type="checkbox"/> TOOTH SIZE | <input type="checkbox"/> SPEECH PROBLEMS |
| <input type="checkbox"/> GUMMY SMILE | <input type="checkbox"/> OVERBITE |
| <input type="checkbox"/> UNDERBITE | <input type="checkbox"/> FACIAL PROFILE |
| <input type="checkbox"/> TEETH ARE DIFFERENT COLORS | <input type="checkbox"/> UGLY OLD CROWNS |
| <input type="checkbox"/> OTHER _____ | |

I AM INTERESTED IN:

- SIX MONTH SMILES (Short-term orthodontic treatment)
- TEETH WHITENING
- VENEERS
- OTHER _____

IS THERE ANYTHING YOU WOULD LIKE THE DENTIST TO KNOW?

PATIENT DENTAL HISTORY

Patient's Dental History

What is your primary reason for seeking dental care?

Previous Dentist Information

Dentist's Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of Last full mouth x-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist?

Annual Check Up

Twice a Year Check Up

Only when I have a problem

Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment? Yes No

Do you gag easily? Yes No

Have you had previous problems with dental care? Yes No

If so, please explain?

Are your teeth sensitive to hot, cold, pressure or sweets? Yes No

Do you have problems with teeth/fillings breaking? Yes No

Are you aware of an uncomfortable bite? Yes No

Do your gums feel tender and/or bleed? Yes No

Does food catch between your teeth? Yes No

Have you had periodontal (gum) treatments? Yes No

Do you get sores in or around your mouth? Yes No

Do you have regular headaches, earaches or neck pains? Yes No

Do you grind or clench your teeth? Yes No

Do you hear a "clicking" sound when you open/close your mouth? Yes No

Does your jaw ever get "stuck"? Yes No

Do you have a Temporomandibular (TMJ) jaw disorder? Yes No

Are you missing teeth that have not been replaced? Yes No

Have you had excessive bleeding after an extraction? Yes No

Do you take any Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia or Zometa? Yes No

Have you had mouth sores that take long to heal? Yes No

Do you have any dental implants? Yes No

Do you wear dentures (partials or full)? Yes No

Do you have any crowns (caps) or bridges? Yes No

Do you chew tobacco? Yes No

Do you have a dry mouth? Yes No

Are you unhappy with the appearance of your teeth? Yes No

Would you like your smile to look better? Yes No

Would you like whiter teeth? Yes No

Do you regularly use dental floss? Yes No

Do you brush at least once daily? Yes No

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site.

Yes No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

City, State and ZIP: _____

Are you currently under a physician's care? Yes No

If Yes, for what?

Have you been hospitalized in the last two years? Yes No

If Yes, for what?

Are you taking any medication, drugs or pills? Yes No

If so, please list the names and dosages of each:

Do you Smoke? Yes No How Much? _____

Women Only

Are you pregnant? Yes No Are you taking birth control pills? Yes No

Are you nursing? Yes No Are you on Hormone Therapy? Yes No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergic to Penicillin | <input type="checkbox"/> Allergic to Codeine | <input type="checkbox"/> Pre-Medication required | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergic to Tetracycline | <input type="checkbox"/> Allergic to 'Novocaine' | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Allergic to Aspirin | <input type="checkbox"/> Allergic to Latex Rubber | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Prior Hepatitis |

Other

Medical Conditions

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Excessive Bleeding when Cut | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gastrointestinal Upset | <input type="checkbox"/> Artificial Joint Replacement |
| <input type="checkbox"/> Congenital Heart Problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Extreme Nervousness |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis A or B | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Deep Vein Clot | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Cortisone Treatment |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> X-Ray or Cobalt Treatment | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Chemical Dependency |



DISTINCTIVE SMILES

OF BATON ROUGE

FINANCIAL POLICY & AGREEMENT

Our goal is to provide you with the highest quality dental care using superior materials and technology. We look forward to helping provide you with up-to-date information and educational tools so that you may participate in the maintenance of your oral health. Our financial policy is intended to allow us to provide excellent service to our patients.

Please initial all boxes after reading each section:

All charges you incur are your responsibility. This is regardless of insurance coverage. You guarantee payment of all such charges. **As your dental care provider, our relationship is with you, our patient, and not with your insurance company.** Your insurance policy is a contract between you, your employer, and the insurance company. Our office policy is not a party to that contract. If payment from your insurance company is not received within forty-five (45) days from the date of service, you will be expected to pay the balance in full.

As a courtesy to you, we may help you process your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing this agreement. It is the patient's responsibility to contact our office with any changes prior to the next visit. If advance notice is not given prior to your appointment, you will be required to pay for the visit in full and seek reimbursement from your insurance provider directly.

Payment is due at the time service is provided. Our office accepts cash, American Express, MasterCard, Discover, and Visa. Outside financing is available for patients through Care Credit or Springstone upon request and approval. Emergency patients not of record must pay cash or credit card prior to being seen by the dentist.

All unpaid balances over 90-days will be sent to a collection agency to assist in the collection of the unpaid balance. You shall be liable for all collection fees at a rate of 33% of the unpaid balance. Please feel free to ask any questions regarding this Financial Policy and Agreement. We are committed to providing you with a positive dental care experience.

Print Name

Signature

Date

Street Address (Not P.O. Box)

City, State, Zip

Telephone Number

CONSENT FOR TREATMENT / PAYMENT

I hereby give my consent for Distinctive Smiles of Baton Rouge, L.L.C. to provide dental services to _____. I agree to be examined and treated according to the recommendations of Dr. Sancerie O'Rourke-Allen and/or her associates. I acknowledge my responsibility to pay for the dental treatment received. Furthermore, I understand that any insurance agreement that I have is an agreement between me and the insurance company. I am responsible for any costs incurred that are not paid by the insurance company.

Payment is expected at the time of service.

We reserve the right to refuse service to anyone.

Signature of Responsible Party

Date

PARENTAL CONSENT FORM

I, _____, do hereby give my consent for the dental treatment of my child _____ in my absence by Distinctive Smiles of Baton Rouge, L.L.C, when accompanied by the following adult(s):

Adult #1: _____

Adult #2: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 20__.

Printed Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Distinctive Smiles of Baton Rouge

Address: 8894 Airline Highway Suite M

City/State/Zip: Baton Rouge, LA 70815