

# Dental Registration and History NV



*Confidential*

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ 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(ies) 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 or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 3 DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

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**HEALTH HISTORY**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- |  |  |                       |  |                                 |   |
|--|--|-----------------------|--|---------------------------------|---|
| AIDS/HIV   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Anemia   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                   | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Artificial Heart Valves                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath             | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Artificial Joints                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                   | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Asthma   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                       | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Back Problems                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                    | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                          | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Blood Disease                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles          | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Cancer   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands             | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Chemical Dependency                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Chemotherapy                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Circulatory Problems                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Congenital Heart Lesions                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Cortisone Treatments                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                           | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Cough, persistent or bloody                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Diabetes   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained        | <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Emphysema  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |   |
|  |  | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                 |   |

Do you wear contact lenses?  Yes  No

**Women:**

Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

**MEDICATIONS**

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

**ALLERGIES**

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         | _____                                     |

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**PHONE NUMBERS**

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

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**UPDATE** (To be filled in at future appointment)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Darrell P. Bourg, Jr., D.D.S.**  
**2521 Ames Blvd. Ste.C**  
**Marrero, LA 70072**  
**(504)340-9696**

**-Notice of Privacy Practices-**

I understand that my healthcare information concerning my diagnosis, treatment, payment, and Insurance will be disclosed when necessary for filing my insurance, and in communicating with other health professionals in the course of my treatment or their offices. Limited information will also be disclosed to business supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel, answering services, and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.

I understand that my files are stored on shelves in the business office. Only staff and janitorial personnel may have access to this office during non business hours. I understand that this office will make every effort to keep your information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy, or inspect and correct my healthcare information, the right to restrict disclosures and obtain an accounting of disclosures. I have the right to voice my concern about privacy to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. (A minimal fee (.20/page) will be charged to me for copies of records that I request).

I understand that I will receive communication in the form of phone calls and/or postcards to remind me of an existing appointment, or that it is time to schedule an appointment. I may receive mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mails or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voice mail.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance claims, and health care operations. This offer retains the right to revise the privacy policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I have read this form and do not wish to sign.

\_\_\_\_\_ (Please initial)

*Louisiana Dental Spa*

**Consent for Dental Treatment and  
Acknowledgement of Receipt of Information**

State Law requires us to obtain your consent for dental treatment. Please do not hesitate to ask us to explain anything to you that you may not understand before treatment is rendered. This is a general consent for treatment form. All of your options and a thorough explanation of the procedures will be given to you.

I understand dentistry is not an exact science and complications may occur despite our best efforts. There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

- |  |   |
|--|---|
| Sensitivity to temperature (hot/cold)  | Damage to or possible loss of fillings or other dental work |
| Damage, fracture or possible loss of the tooth/teeth being treated as well as adjacent teeth and bone            | Change in bite  |
| Failure of wound to heal   | Incomplete removal of tooth                                 |
| Injuries to adjacent teeth and/or soft tissue  | Loss of tooth/teeth or loss of bone                         |
| Paresthesia or numbness of: tongue, and/or mouth, and/or face  | Dry socket  |
| Fracture of mandible (upper jaw) or maxilla (lower jaw)  | Injury to adjacent structures                               |
| Opening between mouth and sinus or mouth and nose  | Instrument breakage   |
| Slough (unanticipated loss of hard and/or soft tissue)   | Allergic reaction to drugs                                  |
| Swallowing and/or aspiration of prosthesis and other objects   | Bacterial Endocarditis                                      |
| Trismus (jaw pain or difficulty opening mouth)   | Failure or treatment to accomplish its purpose              |
| Additional surgery, hospitalization and/or further treatment may be required in the event of any complication(s) | TMJ Dysfunction or worsening of TMJ condition               |
| Burns from chemical agents used in treatment or dental treatments  | Injury from airborne particles or instruments               |
| Loss of or damage to the ability to taste, speak, hear and/or see  | Infection   |
| Breakage or root(s) and retained root fragments  | Bleeding  |
|  | Tooth or fragment in maxillary sinus                        |

State Law also requires that I specifically advise you, although rarely occurring, the dental treatment or anesthetic may result in: Paraplegia (paralysis of both legs); Quadriplegia (paralysis of both arms and legs); Loss or loss of function of an organ(s) or limb(s); Brain Damage; or Death.

**Acknowledgment**

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction. I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

\_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**Date**

**DARRELL P. BOURG, JR. D.D.S.**  
**LOUISIANA DENTAL SPA**  
2521 Ames Blvd., Ste.C  
Marrero, La 70072  
Phone: 504-340-9696 Fax: 504-340-7207

## **SCHEDULING/APPOINTMENT AGREEMENT**

To offer quality care to all of our patients, you are seen by appointment. By doing this, we may be ready and able to see you in a timely manner. We strive for prompt service so that you will not be left waiting. Therefore, we ask that you **ARRIVE ON TIME** for your appointment. Due to the volume of patients needing our care we also ask, should a change in your schedule occur you call to reschedule at least **24 HOURS** prior to your appointment. If proper notice is not given, this will result in a **\$50.00 Missed Appointment Fee** for each hour scheduled. As a courtesy, we will call you prior to your appointment as a reminder. This way any fee for a missed appointment can be avoided. By managing our schedule this way, we are continuously aware of expected patients and can see emergencies promptly. We thank you for your cooperation.

\_\_\_\_\_  
Signature of patient, parent, or responsible party

\_\_\_\_\_  
Date

## **FINANCIAL ARRANGEMENTS**

**Payment for services is due in full at the time services are rendered** unless prior arrangements are made with our office.

If your scheduled appointment time for treatment is **1 ½ Hrs or Greater a 50% Deposit towards your portion due** is required at the time the appointment is scheduled.

## **IMPORTANT INFORMATION ABOUT INSURANCE**

Our office agrees to file your insurance as a courtesy to you. You are responsible for monitoring the use of your benefits and remaining within your maximum covered benefit during each year of coverage. *The amount we estimate your insurance to pay is just that, AN ESTIMATE. The deductible and estimated percentage that your insurance company does not cover is to be paid upon the date of service.*

**Please note that our fees are not based on any insurance schedules, and may be above insurance allowances.**

**After 45 days, any balance from unpaid insurance claims (for example, rejected/denied/or partial payment) will be your responsibility.**

\_\_\_\_\_  
Signature of patient, parent, or responsible party

\_\_\_\_\_  
Date