LAKE CHARLES
FAMILY DENTAL CARE
DARREN W. CHAUMONT DDS

Name: _____ (Male Female) DOB: _____
(Last) (First) (MI) (Preferred Name)

Address: _____ City: _____ State: ___ Zip: _____ Email Address: _____

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

Social Security: _____ Employer/School: _____

Spouse/Parent Employer: _____ Business Phone: _____

Dental Insurance Information (Only fill out for the insured person):

Name:_____ DOB:_____ Social Security Number/ID:_____

Employer:_____ Dental Insurance Co._____ Group Number:_____

Who is responsible for this account: _____ Relation to patient:_____

Emergency Contact: _____ Relation: _____ Phone: _____

Referred by: Phonebook _____Family/ Friend_____ Other_____

Medical History:

Doctor's Name: _____ Address: _____ Phone: _____

Are you currently under the care of a physician? Y/N If yes, please explain: _____

Are you taking any medications? Y/N Please list all (herbal & prescription) : _____

_____

Please list any allergies: (medications, latex, etc..)_____

Please check the appropriate boxes:

PRE-MED REQUIREMENTS
- ☐ Artificial (prosthetic) heart valve
- ☐ Previous infective endocarditis
- ☐ Damaged valves in transplanted heart
- ☐ Congenital heart disease (CHD)
- ☐ Heart transplant
- ☐ Artificial joint (Hip, knee, etc.)

CARDIOVASCULAR
- ☐ Heart disease/attack
- ☐ High blood pressure
- ☐ Prior infective endocarditis
- ☐ Congenital heart disease
- ☐ Artificial heart valve
- ☐ Heart transplant
- ☐ Stroke
- ☐ Blood thinners
- ☐ MVP
- ☐ Pacemaker
- ☐ Stents

NEURAL & SENSORY
- ☐ Epilepsy/seizures/convulsions
- ☐ Nervousness
- ☐ Glaucoma
- ☐ Hearing aid

GASTROINTERNAL
- ☐ Stomach/Intestinal ulcers
- ☐ Hepatitis
- ☐ Liver disease

RESPIRIATORY
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Sleep apnea/breathing problems

ENDOCTINE
- ☐ Diabetes
- ☐ Thyroid disease

DERMAL/MUCOSOCUTANEOUS MUSCULOSKELETAL
- ☐ Allergy to latex
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Mouth ulcers or canker sores
- ☐ Colored or discolored areas in mouth

HEMATOLOGIC
- ☐ Blood tranfusion
- ☐ Tendency to bleed longer
- ☐ Sickle Cell Anemia or trait

SEXUALLY TRANSMITTED
- ☐ Sexual transmitted disease (Syphilis, gonorrhea, chlamydia, genital herpes, HPV)
- ☐ HIV/AIDS

OTHER
- ☐ Use tobacco
- ☐ Use alcohol
- ☐ Drug/alcohol addiction (recovering/ current)
- ☐ Chemotherapy
- ☐ Organ/Cell transplant

Disease, problem, or condition not listed? Y/N If yes, please explain:_____
Is there anything else we should know about your medical history? _____

(Women)
Do you suspect that you are pregnant? ☐ YES ☐NO Due Date: _____ Are you nursing? ☐ YES ☐ NO
Taking birth control pills? ☐ YES ☐NO

Dental History

Are you interested in Sedation Dentistry? ☐YES ☐NO
Are you interested in whitening your teeth? ☐YES ☐NO
Are you satisfied with the color or shape of your teeth? ☐YES ☐NO
Do you suffer from migraines or tension headaches? ☐YES ☐NO
Do you clinch or grind your teeth? ☐YES ☐NO
Do you have clicking, popping, or discomfort in the jaw? ☐YES ☐NO
Do you feel tired throughout the day? ☐YES ☐NO
Do you or your partner snore? ☐YES ☐NO
Have you ever had any periodontal (gum) treatment? ☐YES ☐NO
Do your gums bleed when you floss? ☐YES ☐NO
Do you have problems with bad breath? ☐YES ☐NO
Do you suffer from dry mouth? ☐YES ☐NO
Are any of your teeth sensitive to cold or sweets? ☐YES ☐NO
Is your home water supply fluoridated? ☐YES ☐NO
Do you require antibiotics before dental treatment? ☐YES ☐NO
Is there anything that you would like to change about your smile? ☐YES ☐NO
If yes please explain: _____
Have you ever had an injury to your jaw or face? ☐YES ☐NO
If yes please explain: _____
Have you had any complications associated with dental treatment? ☐YES ☐NO
If yes please explain: _____

Office Policies

Account responsibility:

Our office wants to make it as easy as possible for you to have the financial arrangements to receive your dental care. We accept cash, cashier checks, care credit, Bux Exchange, and credit cards (Visa, Mastercard & Discover). Personal checks are not accepted. We proudly offer **Care Credit payment plans with 0% interest for up to 12 months**. Care Credit is available for all patients regardless if they have dental insurance or not. For any reason should a refund be requested on your Care Credit account a 10% processing fee will be applied. Payment is due at the time services are rendered. A deposit may be required to reserve your next appointment for some basic or major treatment for new patients, patients who have a history of cancellations, or if any prescriptions are given. Deposits will be forfeited if the patient fails their appointment or cancels without proper notice (at least 24hrs notice). Should your account become inactive after twelve (12) months any unused credits on your account will expire. If you have dental insurance and we have verified it, you will be responsible for your deductible and an estimated portion of your treatment. Please be aware that this is just an estimate and any remaining balances after your insurance provider has made payment will be your responsibility to pay in full. To avoid any outstanding balances we offer up to a 15% discount if you pay in full regardless of insurance benefits. After insurance has paid on the claim any remaining credit can be refunded to you. Some insurance companies mail the payment to the patient instead of the office. If you receive an insurance payment you must sign and bring the check to the office since this is payment for services rendered at our office. Failure to do so is considered insurance fraud and will be prosecuted. Our office may contact you by voicemail, text message, email and or regular mail regarding any account balance information. Any patient with an account balance over 90 days regardless if an insurance claim is pending will be sent a letter stating if full payment is not received in two weeks that the account will be turned over to an attorney's office or collections.

Cancellation policy:

We understand that your time is very valuable and we make every effort to ensure that your waiting time in our office is minimal. Each appointment is a time reserved especially for you and the type of treatment you require. We kindly request that if you need to change an appointment that you give us 24 hours notice. Broken appointments disrupt our schedule, causing a delay in your treatment and the treatment of others who could have been scheduled for that appointment. Delaying treatment will cause the condition or disease to worsen, requiring more extensive/expensive treatment or possible tooth loss. Patients that break appointments without proper notice may lose their deposit or be asked to pre-pay in full for all future visits until decided otherwise by the office. A $35 cancellation fee will apply.

Consent

I certify that I have read this form and have answered all questions truthfully. I understand that if I have any changes in my medical history that it is my responsibility to inform Dr. Chaumont or a member of his team. By signing this form I agree to comply with the above mentioned policies.

Patient/Guardian Signature Date

LAKE CHARLES
FAMILY DENTAL CARE
DARREN W. CHAUMONT DDS

(337) 477-8931

Please read about our new services and special offers!

1. <u>Financing for up to 12 months no interest through Care Credit</u>

Advantages of this service include:

- Can be used for all dental work regardless of insurance.
- Dental work can be started the same day that you apply.
- Dental work can be finished faster. (The longer dental work is delayed, the more extensive & expensive it becomes.)
- No out of pocket expense until you receive your first statement from Care Credit.
- Can be used for both Dental & Medical where accepted.
- ➢ Simply fill out the Care Credit application form and hand it to a team member so they may find out your approval status while you fill out the other patient forms!

2. <u>Oral Conscious Sedation for all dental work</u>

Advantages of sedation dentistry include:

- Dental work is performed while you are relaxed & comfortable.
- Less stress, fear, or anxiety during dental work.
- Reduces gag reflex.
- More dental work can be completed in fewer appointments.
- Less time you have to miss from work or school, saving you time & money.
- ➢ Are you interested in more information about Oral Conscious Sedation? **YES____ NO____**

3. <u>Fluoride Varnish Applications</u>

- As recommended by the American Dental Association, fluoride varnish applications for all patients should be done twice a year due to its increased therapeutic levels which help aid in blocking the formation of cavities. Unfortunately, most insurance companies only cover fluoride applications once a year for children 18 and under. Fluoride applications for adults are not covered at all by insurance even though it is very beneficial.
- For the above reasons we request that you let us know if you would like to benefit from fluoride treatments at each of your hygiene visits. If you choose yes then the ***$25.00 fee*** will need to be collected at the time of service.
- ➢ Do you want to receive *Fluoride Varnish* today? **YES____ NO____**

4. <u>Discount Dental Plan</u>

- Save up to **75% Off** for you and your family by enrolling in our *Discount Dental Plan*.
- Receive two (2) free cleanings, x-ray series, and exams per year as part of your benefits.
- Receive **20% Off** on all other dental services!
- ➢ Are you interested in more information about our Discount Dental Plan? **YES____ NO____**

5. <u>$99 Lifetime Teeth Whitening</u>

- Enroll in our Lifetime Teeth Whitening program for only $99!
- Have whiter, brighter teeth *For Life!!*
- ➢ Are you interested in more information about Lifetime Teeth Whitening? **YES____ NO____**

LAKE CHARLES
FAMILY DENTAL CARE
DARREN W. CHAUMONT DDS

(337) 477-8931
Web: www.lcdentalcare.com
Email: lakecharlesdental@yahoo.com

Consent for Dental Treatment

Dental treatment includes but is not limited to the following:
Radiographs, prophylaxis, periodontal and gum treatments, root canal therapy, resin/amalgam/temporary fillings, sealants, crowns, bridges, implants, partials, dentures, extractions, oral surgery, local anesthesia, whitening, cosmetic procedures, nitrous oxide, dermal fillers, botox, and oral sedation.

Risks and complications associated with dental treatment:
I understand there are risks and complications associated with dental treatment and anesthesia. I understand that if treatment is accompanied with complications, I may be referred to a specialist for follow-up care. It is in my best interest to follow all pre and post-op instructions as directed to minimize the potential for complications.

Complications following dental treatment include but are not limited to:
Injuries to adjacent teeth or soft tissue, sensitivity, reversible/irreversible pulpitis, pain, dry sockets, failure to heal properly, retained roots, bone fragments, bleeding, sinus infections, separated instruments, aspiration of objects, jaw fracture, parasthesia or prolonged numbness in tongue, jaw or lips. Allergic reactions to anesthesia or materials used in treatment and medications prescribed. Nausea, infections, bacterial endocarditis. I understand that if any of the above complications occur, it may be necessary to be seen by a specialist or at a hospital for a chest x-ray to resolve any issues. I understand that any additional treatment will require additional fees that will be the responsibility of the patient. I understand, although rare, that even with all precautions and follow up care those complications during or after treatment can result in death.

Acknowledgment of consent
I have read the above thoroughly and understand the risk and complications associated with dental treatment. I understand the success of dental treatment is not guaranteed. I understand the outcome of my treatment partially depends on my compliance with follow-up care, recall appointments, and proper oral hygiene at home. I understand that I must notify Dr.Chaumont at the first sign of a complication to ensure that I receive the proper follow-up care.

I understand all the above and have been given an opportunity to ask questions. I understand by signing this form I give my consent to allow Dr. Chaumont to perform all diagnostic, routine and surgical dental procedures accompanied by the necessary anesthesia. I understand that this consent form will remain valid for any procedure performed in Dr. Chaumont's office until it is revoked by me in writing. I understand that for each procedure I will have the opportunity to ask questions and be given a specific form providing more detailed information for the specific procedure. However the specific forms are only for my information and do not need to be signed and returned since this "Consent for Dental Treatment" acts as my consent for all dental procedures.

Signature of Patient/legal guardian: _____Date:_____

Print name: _____

LAKE CHARLES FAMILY DENTAL CARE
DARREN W. CHAUMONT DDS
(337) 477-8931
4001 Louisiana Ave.
Lake Charles, LA 70607
Web: www.lcdentalcare.com
Email: lakecharlesdental@yahoo.com

Acknowledgement of Receipt of Privacy Practices Notice

By signing below you are stating that you have had the opportunity to read and/or ask for a copy of our office's privacy policy.

Any information regarding a patient under the age of 18 will only be released to the patient's legal guardian(s).

Date: _____

Patient name: _____

Patient signature: _____

Guardian name: _____

Guardian signature: _____

If you would like any information released to anyone other than the above mentioned, please list their name and relation to the patient below:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

For office use only

Describe your good faith effort to obtain the individuals signature on this form and why the individual would not sign this form:

_____

_____

_____

CareCredit℠

APPLICATION AND CREDIT CARD ACCOUNT AGREEMENT

A credit service of GE Capital Retail Bank

For Providers: **(800) 859-9975**
For Patients/Clients: **(800) 365-8295**

Submit by internet: **CARECREDIT.COM**

** **MARRIED WI Residents only:** If you are applying for an individual account and your spouse also is a WI resident, combine your and your spouse's financial information.

ESTIMATED FEE $	**Office Merchant #**	Pre-Approval Offer ❑ Accepted ❑ Refused Date _____

Photo ID verified (initial):	Applicant 1st ID Type / Number # _____ ❑ Driver's License ❑ State Issued ❑ Federal Government	Issuance State	Exp. Date	Applicant 2nd ID Type / Issuer	Exp. Date
Provided by GE Capital Retail Bank:	Account #	Authorization # or Key #		Approved Credit Limit	

1. APPLICANT INFORMATION: Please tell us about yourself. Please note that you must reside in the United States and be 18 years or older to apply.

Name (First-Middle-Last) Please Print	Date of Birth / /	Social Security Number - -	Home Phone Number* ( )
Mailing Address Apt.# City State Zip			Cell/Other Phone Number* ( )

If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. ❑ Your Address? ❑ Contact Person?
Contact Person Name Street Address (Street Name and Number) City State Zip

Housing Information ❑ PARENTS/RELATIVE ❑ OWN ❑ RENT ❑ OTHER	Nearest Relative Phone Number* ( )	Alimony, child support or separate maintenance income need not be included unless relied upon for credit. You may include the monthly amount that you have available to spend from your assets. **	Monthly Net Income From All Sources $_____	Employer's Phone Number* ( )

E-Mail Address (optional)*

*You authorize GE Capital Retail Bank ("GECRB") to contact you at each phone number you have provided. By providing a cell phone number and/or email address, you agree to receive special offers, updates and account information, including text messages, from Providers that accept the GECRB credit card. Standard text messaging rates may apply.

2. JOINT INFORMATION:

An additional card will be issued to the person indicated below. The applicant (and joint applicant, if any) will be liable for all transactions made on the account including those made by any authorized user. JOINT APPLICANT: You agree that we may send notices to you and/or applicant at the applicant's address, regardless of whether you live at that address.

Name (First-Middle-Last) Please Print	Date of Birth / /	Social Security Number - -	Home Phone Number * ( )
Mailing Address Apt.# City State Zip			Cell/Other Phone Number * ( )

If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. ❑ Your Address? ❑ Contact Person?
Contact Person Name Street Address (Street Name and Number) City State Zip

Housing Information ❑ PARENTS/RELATIVE ❑ OWN ❑ RENT ❑ OTHER	Nearest Relative Phone Number * ( )	Alimony, child support or separate maintenance income need not be included unless relied upon for credit. You may include the monthly amount that you have available to spend from your assets. **	Monthly Net Income From All Sources $_____	Employer's Phone Number * ( )

Joint Applicant ID Type / Number # _____ ❑ Driver's License ❑ State Issued ❑ Federal Government	Issuance State	Exp. Date	Joint Applicant 2nd ID Type / Issuer	Exp. Date

E-Mail Address (optional)*

*You authorize GE Capital Retail Bank ("GECRB") to contact you at each phone number you have provided. By providing a cell phone number and/or email address, you agree to receive special offers, updates and account information, including text messages, from Providers that accept the GECRB credit card. Standard text messaging rates may apply.

3. APPLICANT and JOINT APPLICANT: We need your signature(s) below.

By applying for this account, I am asking GE Capital Retail Bank ("GECRB") to issue me a CareCredit Credit Card (the "Card"), and I agree that:

- I am providing the information in this application to GECRB, CareCredit LLC, and providers that accept the Card and program sponsors. GECRB may provide information about me (even if my application is declined) to CareCredit LLC, providers that accept the Card and program sponsors (and their respective affiliates) so that they can create and update their records, and provide me with service and special offers.
- GECRB may obtain information from others about me (including requesting reports from consumer reporting agencies and other sources) to evaluate my application, and to review, maintain or collect my account.
- I consent to GECRB and any other owner or servicer of my account contacting me about my account, including using any contact information or cell phone numbers I provide, and I consent to the use of any automatic telephone dialing system and/or an artificial or prerecorded voice when contacting me, even if I am charged for the call under my phone plan.
- I have read and agree to the credit terms and other disclosures in this application, and I understand that if my application is approved, the GECRB credit card account agreement ("Agreement") will govern my account. Among other things, the Agreement: **(1) includes a resolving a dispute with arbitration provision that limits my rights unless I reject the provision by following the provision's instructions;** and (2) makes each applicant responsible for paying the entire amount of the credit extended.

PLEASE SEE NEXT PAGE FOR RATES, FEES AND OTHER COST INFORMATION.

Federal law requires GECRB to obtain, verify and record information that identifies you when you open an account. GECRB will use your name, address, date of birth, and other information for this purpose.

If I have been pre-approved, I request that you open the type of account for which I was pre-approved. I have read the Prescreen Disclosures, credit terms and other disclosures on the next pages and have been provided my credit limit applicable to the account. **GECRB reserves the right to refuse to open an account in my name if GECRB determines that I no longer meet GECRB's credit criteria or if I do not have the ability to make the minimum payments on the account.**

If you apply with a Joint Applicant, each of you will be jointly and individually responsible for obligations under the Agreement and by signing below, you each agree that you intend to apply for joint credit.

Signature of Applicant		Signature of Joint Applicant (If Applicable)	
X _____ (Please Do Not Print)	Date_____	X_____ (Please Do Not Print)	Date_____

LAKE CHARLES FAMILY DENTAL CARE
DARREN W. CHAUMONT DDS

No Dental Insurance? No problem!

Ask about our *DENTAL DISCOUNT PLAN*

The *Dental Discount Plan* is our in-office benefit plan that has been developed to deliver quality dental care services to families like yours, at prices that make sense for today's economy.

Services included in membership:

- Two simple hygiene cleanings per member (codes D1110 or D1120)
  (Prophylaxis only, not advanced services such as root planning or debridement)
- Two exams per member (codes D0150 or D0120)
- X-ray series per member (codes D0210 or D0274)
- Any other services performed regardless if cosmetic or restorative are **20% off**
- A $25.00 co-pay due is due on emergency visits. If treatment is done same day or payment is made toward future treatment then the $25.00 co-pay will be waived.

Advantages of the *DENTAL DISCOUNT PLAN* vs. traditional insurance coverage:

- ✓ No waiting periods. You can start treatment as soon as you enroll.
- ✓ No missing tooth clause or pre-existing exclusions.
- ✓ No deductibles or yearly maximums for benefits.

Enrollment Fees:

- $225 for single member per enrollment period. (Value of $370, you save 40%)
- $325 for two members per enrollment period. (Value of $740, you save 55%)
- $425 for three members per enrollment period. (Value of $1110, you save 60%)
- $525 for four members per enrollment period. (Value of $1480, you save 65%)
- $99 for each additional beyond 4 members

Who is Eligible?

- Anyone and everyone regardless of their dental conditions are eligible
- People with no dental insurance or who have met their maximum limit under traditional insurance plans

Exclusions:

- Plan is valid only for services provided in office by Dr. Chaumont and/or staff.
- Dental materials, merchandise or products are not covered (ex. Water flossers, toothpaste, whitening trays/gels, appliances)
- If a member should become covered by a traditional dental plan or Medicaid then this plan becomes null and void with no refund of fees
- Any treatment or anesthesia fees performed under IV sedation are not covered.
- May not be used in conjunction with any other office promotions/discounts.
- Additional members may not be added after the enrollment period begins.
- Botox/Dermal Fillers services are not covered.

How do I Start and When Will Benefits Begin and End?

Benefits begin immediately after the annual enrollment fee has been paid. Benefits will be valid for one year from date of enrollment. Re-enrollment fees will be due annually if you desire to keep your benefits.

Patient Payments

All payments are made directly to the dental office and will be collected in full prior to the start of scheduled treatment. Patients that choose to pay for their visit using CareCredit will only receive 10% off dental services.

LAKE CHARLES FAMILY DENTAL CARE
DARREN W. CHAUMONT DDS

DENTAL DISCOUNT PLAN – Enrollment Form

Members Information (Please Print):

1. Member Responsible for Account: _____ ($225 fee)
(Last) (First) (MI)

2. Name: _____ ($325 fee)
(Last) (First) (MI)

3. Name: _____ ($425 fee)
(Last) (First) (MI)

4. Name: _____ ($525 fee)
(Last) (First) (MI)

5. Name: _____ ($99 fee)
(Last) (First) (MI)

6. Name: _____ ($99 fee)
(Last) (First) (MI)

7. Name: _____ ($99 fee)
(Last) (First) (MI)

Total number of members_____ **Total enrollment amount $_____**

I, _____, have read the information regarding the *Dental Discount Plan* and understand that this is NOT a dental insurance plan. I have had the opportunity to ask any questions and I am aware that it is my responsibility to share information about the savings plan with all members that I choose to cover. I understand in order to receive the 20% discount that a non-refundable deposit will be collected prior to scheduled treatment. The deposit will be forfeited if the appointment is failed or broken without proper notice. I understand that if a hygiene appointment is failed or broken without proper notice that appointment will be forfeited from the plan. I understand that Dr. Chaumont reserves the right to discontinue this plan at any time for any member.

_____

Member signature responsible for account Date of Enrollment

Please mail or drop off completed application with corresponding payment to:

Lake Charles Family Dental Care
Darren W. Chaumont DDS LLC
4001 Louisiana Ave
Lake Charles, LA 70607
337-477-8931
www.lcdentalcare.com

For Office Use Only

1st Hyg Visit:_____

2nd Hyg Visit:_____