PATIENT NAME: _____ TODAY'S DATE: _____

HOME ADDRESS: _____ DATE OF BIRTH: _____

_____ HOME PHONE: _____

E-MAIL: _____ CELL PHONE: _____

EMPLOYER: _____ BUSINESS PHONE: _____

INSURANCE CO: _____ SS#/SIN: _____

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN: _____ OFFICE PHONE: _____ DATE OF LAST EXAM: _____

		YES	NO
1	Are you under medical treatment now?	☐	☐
2	Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3	Are you taking any medication(s) including non-prescription medicine?	☐	☐
	If yes, what medications are you taking?	☐	☐
4	Have you ever taken Fen-Phen/Redux?	☐	☐
5	Do you use tobacco?	☐	☐
6	Do you use alcohol, cocaine or other drugs?	☐	☐
7	Are you wearing contact lenses?	☐	☐

8 Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg novocaine)	☐	☐	Barbituates	☐	☐	Asprin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other
☐	☐	Sulfa Drugs	☐	☐	Iodine			_____

9 WOMEN ONLY

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10 Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

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

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergy
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low / High Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight-Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually-Transmitted Disease	☐	☐	Other_____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____

COMMENTS:

_____

_____

_____

_____

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_____

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_____

Signature of Dentist Date

PATIENT DENTAL HISTORY

		YES	NO
1	Do your gums bleed while brushing or flossing?	☐	☐
2	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4	Do you feel pain to any of your teeth?	☐	☐
5	Do you have any sores or lumps in or near your mouth?	☐	☐
6	Have you had any head, neck or jaw injuries?	☐	☐
7	Have you ever experienced any of the following problems in your jaw?		
	a) Clicking?	☐	☐
	b) Pain (joint, ear, side of face)?	☐	☐
	c) Difficulty in operating or closing?	☐	☐
	d) Difficulty in chewing?	☐	☐
9	Do you have frequent headaches?	☐	☐
10	Do you clinch or grind your teeth?	☐	☐
11	Do you bite your lips or cheeks frequently?	☐	☐
11	Have you ever had any difficult extraction in the past?	☐	☐
12	Have you had any orthodontic treatment?	☐	☐
13	Have you ever had prolonged bleeding following extractions?	☐	☐
14	Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15	Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE **X** _____ _____

PATIENT, PARENT OR GUARDIAN DATE

Dr. Kellene M. Cole, D.D.S. & Associates
9541 Jefferson Hwy. LA 70123
(504) 738-1567

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental or medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our policy.

Payment for services is due at the times services are rendered. We accept checks, MasterCard, Visa, Discover, American Express, and Care Credit. We will be happy to help you process your insurance claim form at each visit. Any accounts balances over sixty (60) days will be subjected to an 18% APR. If this account becomes delinquent I agree to pay all collection costs, court costs, or attorney fees if it becomes necessary to bring this account to a collection agency.

We will gladly discuss our proposed treatment plan and answer any questions relating to your insurance. You must realize, however, that:

1. Your entrance is a contract between you, and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range for most companies.
3. Not all services are a covered benefit and all contracts. Please read you dental benefit booklet.

We must emphasize that a dental care providers, our relationship is with you, but your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timing payments of your account.

If you have any questions about the above information or questions regarding insurance coverage please do not hesitate to ask us. We are here to help you.

Patient Information

Name: _____

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

Spouse's Phone: _____ Spouse's Phone: _____

Whom may we thank for referring you to us: _____

Insurance Information

Insurance Company: _____ Insurance Company Phone: _____

Insurance Subscriber: _____ D/O/B: _____SS#: _____

Insurance Policy Number: _____ Group Number: _____

I understand and agree that I am responsible for the balance on my account for any services rendered; I have read all the information and have answered the above questions. I certify this information is true and correct to the best or my knowledge. I will notify you of any changes of my health status or the above information.

Patient Signature: _____ Date: _____

(Guardian Signature if patient is a Minor)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Kellene M. Cole, D.D.S. & Associates
9541 Jefferson Hwy. LA 70123
(504) 738-1567

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand is that this organization has the right to change Its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient signature and in acknowledgement on this notice of Notice of Privacy Practices acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

Dr. Kellene M. Cole, D.D.S. & Associates
9541 Jefferson Hwy. LA 70123
(504) 738-1567

I authorize the office of Kellene M. Cole, D.D.S. and Associates to answer any questions regarding my dental care to my family member:

_____
Family Member Name

_____
Family Member Name

Patient: _____
Signature