SHREVEPORT-BOSSIER FAMILY DENTAL CARE FOR KIDS

Patient's Name: _____ Patient's Birthdate: _____
(FIRST, MIDDLE, LAST)

Patient's SSN #: _____ Email Address: _____

Phone # Home: _____ Cell: _____ Work: _____

Patient's Address: _____
(Street Address) (City, State, Zip)

How did you hear about us? (Please list specifics, thank you)

Friend or Family Member: _____ Another Doctor's Office: _____

Internet Search or Website: _____ Social Media: _____

TV:_____ Radio:_____ Phonebook:_____

Ad/Coupon Mailing:_____ Other:_____

DENTAL INSURANCE INFORMATION

Primary Insured's Name: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Insurance Company: _____

Insurance Company's Address: _____ Ph #:_____
(Street Address) (City,State,Zip)

Insured's SS #: _____ Policy #: _____ Group # :_____

Insured's Relationship to Patient: _____ Original Effective Date: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party's Name & Relationship to patient: _____

Responsible Party's SSN #: _____ Responsible Party's Birthdate: _____

Responsible Party's Phone #: Home:_____ Cell:_____ Work:_____

Responsible Party's Address: _____
(Street Address) (City, State, Zip)

I authorize the staff of Shreveport Bossier Family Dental Care for Kids to perform any necessary services needed during diagnosis and treatment. I also authorize Shreveport Bossier Family Dental Care for Kids to release any information required to process insurance claims.

I understand the information provided in this form and guarantee that it was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ **Date:** _____
Parent or Legal Guardian

Medical History

Medical Doctor's Name & Phone #:_____

Emergency Contact's Name & Phone#:_____

List all medications you are currently taking, and why you are taking them: _____

_____

Allergic to: _____ Latex _____Codeine _____Penicillin _____ Dental Anesthetics

___ Any Other (Please list): _____

Please List Any *Surgeries or Hospitalizations*:

_____

Please list any additional medical conditions:

_____

Do you have: headaches **Y / N** neck pain **Y / N** jaw pain **Y / N**

If yes, How often: **EVERYDAY / WEEKLY / OCCASIONAL** If yes, Severity of pain: **MILD / MODERATE / SEVERE**

Is there anything you want to talk to the doctor about today?

_____

Do you have or have you had any of the following conditions? **(MUST CIRCLE Y or N)**

Y N Alcohol/ Drug Abuse
Y N Anemia
Y N Arthritis/ Rheumatism
Y N Artificial Heart Valves
Y N Artificial Joints/ Replacement
Y N Asthma
Y N Bacterial Endocarditis
Y N Bleeding Problems
Y N Cancer or Tumors
Y N Chemotherapy/ Radiation
Y N Cold Sores/ Fever Blisters
Y N Congenital Heart Defect
Y N Congestive Heart Failure
Y N Diabetes
Y N Fainting/ Seizures/ Epilepsy
Y N Fetal Alcohol Syndrome
Y N Glaucoma
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery/ Pacemaker/ Stent
Y N Hepatitis
Y N High Blood Pressure
Y N HIV / AIDS / ARC
Y N Hypoglycemia
Y N Kidney Problems
Y N Leukemia
Y N Liver Problems
Y N Mitral Valve Prolapse
Y N Nervousness/ Anxiety
Y N Osteoporosis
Y N Paget's Disease
Y N Psychiatric Treatment
Y N Recent Weight Loss (>10)
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Sexually Transmitted Disease
Y N Sickle Cell Disease/Trait
Y N Sinus Problems/ Allergies
Y N Stomach Problems/Ulcers
Y N Stroke
Y N Thyroid problems
Y N Tuberculosis (TB)

HAS YOUR CARDIOLOGIST, SURGEON, OR OTHER DOCTOR EVER TOLD YOU TO TAKE PREMED BEFORE ANY DENTAL TREATMENT? YES NO IF YES, WHAT PRE-MED DO YOU TAKE? _____

Signature:_____ Date: _____
Parent or Legal Guardian

Shreveport-Bossier Family Dental Care for Kids

3412 Barksdale Blvd., Suite 100, Bossier City, LA 71112

318.213.4693

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Shreveport-Bossier Family Dental Care for Kid's Notice of Privacy Practices, which has an effective date of April 14, 2003, and which describes how my health may be used and disclosed. I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

We at Shreveport-Bossier Family Dental Care for Kids take your dental confidentiality very seriously. We will not and cannot release information without your written authorization. This authorization form, when completed and signed by you, allows our staff members to speak only with an individual or individuals you designate in the event that you are not available to receive phone calls or you have an adult family member that helps coordinate your or your child's dental care.

I authorize employees of Shreveport-Bossier Family Dental Care for Kids to speak with:

NAME:_____ RELATIONSHIP:_____

PHONE NUMBER: _____

____ Appointments ____ Account/Billing ____ Treatment Plan/Decisions ____ Medical History Updates

NAME:_____ RELATIONSHIP:_____

PHONE NUMBER: _____

____ Appointments ____ Account/Billing ____ Treatment Plan/Decisions ____ Medical History Updates

_____I DO NOT AUTHORIZE ANYONE TO RECEIVE INFORMATION REGARDING MY DENTAL CARE.

This authorization will remain in effect unless changed by me while I am a patient of this practice. It is my responsibility to notify this practice of changes and to complete a new form. I agree that should I desire to revoke this authorization, I will give written notice.

Signature:_____ **Date:** _____

Parent or Legal Guardian

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OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. We DO NOT verify insurance benefits; therefore, it is the full responsibility of the patient to know and understand their individual insurance benefits, waiting periods, and all exclusions or limitations.

In consideration for the professional services rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are performed, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned over to for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

I UNDERSTAND THAT MY CO-PAYMENT IS AN "ESTIMATE" ONLY AND THAT THERE IS NO WAY OF KNOWING EXACTLY WHAT MY INSURANCE COMPANY WILL PAY. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY UNPAID BALANCE, REGARDLESS OF ANY INSURANCE I MAY OR MAY NOT HAVE.

Signature:_____ **Date:** _____

Parent or Legal Guardian

(Rev. 8/16)

Shreveport-Bossier Family Dental Care for Kids

3412 Barksdale Blvd., Suite 100, Bossier City, LA 71112

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MEDIA RELEASE

I hereby agree and give my permission for Shreveport Bossier Family Dental Care for Kids to record, film, photograph, publish, audiotape or videotape my name, image, likeness, spoken or written words, in any form (hereinafter collectively referred to as "Works"), and to freely use, display, publish, distribute or exhibit these Works or any part thereof for the purpose of and in connection with any material that may be created by Shreveport Bossier Family Dental Care for Kids for any and all current or future use in commercial or non-commercial form or distribution, including, without limitation, for print publication, website posting and/or for video, DVD and/or other media outlets.

By entering into this informed consent and release and granting the permission as stated herein, I am expressly authorizing Shreveport Bossier Family Dental Care for Kids to use, in whole or in part, my Works in connection with any materials for Shreveport Bossier Family Dental Care for Kids including without limitation, in any and/or all manner and media, as Shreveport Bossier Family Dental Care for Kids determines in their sole discretion. I also understand that Shreveport Bossier Family Dental Care for Kids shall own all rights, title and interest, including the copyright(s), in and to the materials, to be used and disposed in perpetuity without limitation as Shreveport Bossier Family Dental Care for Kids shall determine in their sole discretion unless otherwise prescribed by contract.

By entering into this informed consent and release and granting the permission as stated herein, I also am releasing Shreveport Bossier Family Dental Care for Kids and their respective officers, directors, agents and/or employees from and against any and all liability, loss, damage, costs, claims and/or causes of action arising out of or related to my participation in any media events, including, without limitation, new media film and video productions, print, photography or design projects, television broadcasts, promotional materials or website projects.

I hereby further agree that Shreveport Bossier Family Dental Care for Kids is the sole owner of all rights, title and interest, including copyrights in such Works and any parts thereof for all purposes, as Shreveport Bossier Family Dental Care for Kids shall determine in their sole discretion without limitation, reservation or compensation to me.

I have read this informed consent and understand its terms. I sign it voluntarily and with full knowledge of its significance.

Signature:_____ **Date:** _____

Parent or Legal Guardian