Opelousas Dental, LLC
Bridgette Vidrine, DDS
Brittaney Burke, DDS
506 N Court St.
Opelousas, LA 70570
Telephone: 337-942-3441
Fax Number: 337-942-3461

Date: _____ **MCNA ID#:** _____

Name: _____ Female: _____ Male: _____
Date of Birth: _____ Age: _____
Race: _____ SSN: _____-_____-_____
Language Spoken: English or Other: _____ ☐ Single ☐ Married ☐ Divorced
Parent / Guardian Name: _____
Mailing Address: _____
City: _____ Zip: _____

Telephone: _____
2nd Telephone: _____
Emergency Contact Name and Phone: _____
How did you find out about us? _____

Medical History: Please check a box for *each* item listed.

YES	NO		YES	NO
☐	☐	Asthma	☐	☐ ADD or ADHD
☐	☐	Hepatitis	☐	☐ Substance Abuse
☐	☐	AIDS Virus / HIV	☐	☐ Alcohol Abuse
☐	☐	Epilepsy	☐	☐ Nicotine Abuse
☐	☐	Rheumatic Fever		
☐	☐	Penicillin Allergy		
☐	☐	Codeine Allergy		
☐	☐	Autism		
☐	☐	Heart Problems		
☐	☐	Heat Murmur or Mitral Valve Prolapse		
☐	☐	Special Needs / Mental Health Condition		
☐	☐	Sickle Cell Anemia or Sickle Cell Trait		

Please list any other medical conditions or allergies that your child has or any medications that your child has or any medications that they are currently taking.

1. _____
2. _____
3. _____

I, the parent or legal guardian of the above child, give my permission for my child to be treated by the office of Dr. Bridgette M. Vidrine and Dr. Brittaney N. Burke, Opelousas Dental, LLC.

_____ _____
Signature **Date of Signature**
(Parent / Legal Guardian if Minor Child)

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

I acknowledge that I have read, or the form was read to me and I understand the information on both pages of this consent form. I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about the treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of this treatment and avoidance of treatment complications depends to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my keeping the appointments for treatment of follow up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately or any suspected complications or complications, where further treatment may be discussed, or administered, which is not currently anticipated.

I hereby authorize and direct Dr. Bridgette M. Vidrine and/or Dr. Brittaney N. Burke and/or associates or assistants or her choice to perform the diagnostic, intraoral and extraoral photographs, surgical, or dental treatments. This consent form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waived any further disclosures or information.

Date: _____

_____
Signature of Patient

_____
Signature of Parent/Legal Guardian

_____
Witness

_____
Dentist

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct Dr. Bridgette M. Vidrine and/or Dr. Brittaney N. Burke with associates or assistants of her choice to perform upon _____ diagnostic, surgical, restorative, hygiene and /or any dental procedures deemed necessary including any necessary or advisable anesthesia.

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:
Alternative to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

RISK ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:
I understand that dentistry is not an exact science and that complications may occur despite the best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetic are:

Swelling & bruising which may necessitate staying home for several days.
Breakage of roots
Paresthesia (Permanent or transient numbness of the cheeks, gums, teeth lips, tongue, chin and face)
TMJ dysfunction of worsening of condition
Stretching of mouth which may cause cracking or bruising.
Instrument breakage
Infection
Pain
Loss of taste
Sinus involvement
Blindness (partial or complete in both eyes)
Bleeding may be heavy enough to stop the procedure.
Retained instrument fragment
Loss/damage to adjacent teeth and/or bone.
Change in the bite.
Trismus (Jaw pain or difficulty opening mouth)
Failure of the treatment to its purpose.
Dry socket
Swallowing of object
Fracture of breakage of jaw
Further surgery or treatment.

State law also requires that I specifically advise you that, although rarely occurring, death, brain damage, quadriplegia, paraplegia, loss of organs, loss of function of an organ, loss of function of face, arms, or legs, and disfiguring scars.

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BRITTANEY N. B URKE, DDS
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FAX: 337-942-3461

ACKNOLEDGEMENT OF RECIEPT OF OPELOUSAS DENTAL'S HIPAA POLICY

I acknowledge that I have received a copy of the Notice of Privacy Policy (HIPAA) for Opelousas Dental.

DATE: _____

PATIENT'S NAME: _____
(PRINT)

PATIENT'S SIGNATURE: _____
(GAURDIAN IF PATIENT IS A MINOR)

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Parent's/legal guardians must accompany patients during routine cleaning and exams. Only during regular check-ups will you be allowed into treatment areas. At these check-up appointments you will be informed of all procedures necessary (if any) to restore your child's dental health. However, parent's/legal guardians are required to be seated in waiting areas if further treatment is to be performed at check-up.

If you have any questions or concerns regarding treatment, please notify a member of our staff so that we may have someone speak to you before any work is performed on the patient.

All parent/legal guardians that are unable to attend any appointments must give written consent for anyone else to accompany patient to visits. All persons bringing patients to appointments will be responsible for giving their consent when needed if any treatment should change.

An adult must be on premises at all times during treatment. At no times should you leave or drop a patient off.

_____
Patient Name
(Print)

_____
Parent/Legal Guardian's Name
(Print)

_____
Parent/Legal Guardian Signature

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Date: _____

I, _____ name the following adults as responsible for _____. These adults may accompany the named patient to appointments. Responsible adults will be allowed to conversate about medical and dental information along with making treatment decisions pertaining to the above named child.

Adults allowed to consent for dental treatment:

1) _____

2) _____

3) _____

_____
Parent's name printed

_____
Parent's signature