

**Opelousas Dental, LLC
 Bridgette Vidrine, DDS
 Brittany 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 |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> ADD or ADHD |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> AIDS Virus / HIV | <input type="checkbox"/> | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> Nicotine Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | | |
| <input type="checkbox"/> | <input type="checkbox"/> Penicillin Allergy | | |
| <input type="checkbox"/> | <input type="checkbox"/> Codeine Allergy | | |
| <input type="checkbox"/> | <input type="checkbox"/> Autism | | |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Problems | | |
| <input type="checkbox"/> | <input type="checkbox"/> Heat Murmur or Mitral Valve Prolapse | | |
| <input type="checkbox"/> | <input type="checkbox"/> Special Needs / Mental Health Condition | | |
| <input type="checkbox"/> | <input type="checkbox"/> 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. Brittany N. Burke, Opelousas Dental, LLC.

Signature
 (Parent / Legal Guardian if Minor Child)

Date of Signature

**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 or 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 or 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.

**OPELOUSAS DENTAL, LLC
BRIDGETTE, M. VIDRINE, DDS
BRITTANEY N. B URKE, DDS
506 N COURT ST.
OPELOUSAS, LA 70570
TELEPHONE: 337-942-3441
FAX: 337-942-3461**

ACKNOWLEDGEMENT OF RECEIPT 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)