Opelousas Dental, L.L.C.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

TIME 3:17 PM

DATE 10/21/2010

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

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.

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

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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FAX: 337-942-3461

INSURANCE POLICY

Opelousas Dental is glad to accept your dental insurance as a courtesy to you, our patient. The insurance contract, however, is between you and your insurance carrier, not Opelousas Dental. We will file ass necessary forms to expedite payment to our office. If payment is not received with in 45 days of dental treatment we will expect the payment to be made by you. Any payment received after you payment will be forwarded to you.

We do our best to calculate the insurance portion of our standard fees ass accurately as possible, expecting you to pay your calculated portion at the time of service. Sometimes, a balance may be left after the insurance has made their payment. This balance is your responsibility. Any difference in payment that you feel should have been paid is between you and the insurance company. We verify your maximum benefit available for your treatment and sometimes your insurance company may give us the wrong information. If your maximum is reached any balance is your responsibility.

We do not accept any secondary insurance payments. We would be happy to file any paperwork for you, allowing you to the insurance company to reimburse you personally.

By signing, you agree to the above policy and assign benefits, otherwise payable to me, to Opelousas Dental.

DATE: _____

PRINTED NAME: _____

SIGNATURE: _____
(GAURDIAN ONLY IF PATIENT IS A MINOR)

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CANCELLATION AND BROKEN APPOINTMENT POLICY

We understand that illnesses, emergencies, flat tires, and bad weather do occur. We ask our patients to give a 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and fees:

Cancellation and rescheduling of an appointment *with 48 hours or more* notification – no charge.

Cancellation and rescheduling of an appointment *less than 48 hours up to 24 hours* may or may not be considered a broken appointment; it will be at our discretion.

- We allow (1) broken appointment within a 12 month period.
- Any additional broken appointments will be charged a fee.
  -$25 for a hygiene appointment
  -$50 for a dentist appointment scheduled for an hour or less, each additional hour incurs an additional fee of $50.

Definition of a "broken appointment": A broken appointment is when you

- *Cancel* or *reschedule* and appointment with LESS than 48 hour notice.
- Do not show up for the schedule appointment.

Our number one concern is our patients' dental health and providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without giving adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding out appointment policy and if you have an questions or concerns, never hesitate to ask.

I have read and understand the above policy.

PATIENT'S SIGNATURE (PATENT OR GAURDIAN IF MINOR) DATE