Welcome

Thank you for selecting Houma Family Dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form. If you have any questions, please ask us – we will be happy to help!

HOUMA FAMILY DENTAL

5683 Hwy 311 (985) 868-5699

Today's Date _____

Patient Information (CONFIDENTIAL)

Name _____ SS# _____ DOB _____
Last First Middle

MAILING Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email _____ Primary Language _____ Gender ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ State _____ ☐ Full-time ☐ Part-time

Spouse or Parent's Name _____ Employer _____

Person to contact in case of Emergency? _____ Phone _____

How did you hear about us? ☐ Website ☐ Facebook ☐ Instagram ☐ Friend: _____

Responsible Party

Name of Person Responsible (Insured) for this Account _____ Relationship to Patient _____

SSN# _____ DOB _____ Driver's License # _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Employer of Insured _____ Work Phone _____

Name of Primary Insurance _____ Member ID # _____ Group # _____

Name of Secondary Insurance _____ Member ID # _____ Group # _____

For your convenience, we offer the following methods of payment. Please select the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ CreditCare

Medical History

Name of Physician _____ Office Phone _____Last exam date _____

PLEASE CHECK YES OR NO TO EACH.	YES	NO
Are you under medical treatment now?		
Have you ever been hospitalized for any surgical operation or serious illness?		
If yes, explain: _____		
Are you taking any medications including non-prescription?		
If yes, list: _____		
Have you ever taken Phen-Fen/Redux?		
Do you use controlled substances?		
Are you wearing contact lenses?		
Do you use tobacco?		
WOMEN ONLY:		
Are you pregnant or think you may be?		
Are you nursing?		
Are you taking oral contraceptives?		

	YES	NO
Are you allergic to or have any reactions to the following?		
Local anesthetics (Novocain, etc.)		
Penicillin or other antibiotics		
Sulfa drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Any metals		
Latex rubber		
Other, please list: _____		
Do you have or have had asthma?		
If yes, date of last attack _____		

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY.

Anemia	Epilepsy/Convulsions	Hepatitis	Low Blood Pressure	Sexually Transmitted Disease
Angina	Fainting/Seizures	High Blood Pressure	Mitral Valve Prolapse	Stomach Troubles/Ulcers
Arthritis	Frequently Tired	HIV/AIDS infection	Pacemaker	Stroke
Asthma	Glaucoma	Jaundice	Physical/Mental Disability	Swollen Ankles
Cancer	Heart attack	Joint Replacement/Implant	Radiation Treatment	Thyroid Problems
Chest pains	Heart disease	Kidney Disease	Recent Weight Loss	Tuberculosis
Diabetes	Heart murmur	Leukemia	Respiratory Problems	Other: _____
Emphysema	Heart trouble	Liver Disease	Rheumatic Fever	_____

Patient Dental History

Name of Previous Dentist and Location _____Last exam date_____

PLEASE CHECK YES OR NO TO EACH.	YES	NO
Do your gums bleed while brushing?		
Are your teeth sensitive to hot or cold liquids/foods?		
Do you feel pain to any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any head, neck or jaw injuries?		
Have you ever experienced the following in your jaw? Clicking?		
Pain (joint, ear, side of face)?		
Difficulty in opening or closing?		
Difficulty in chewing?		

	YES	NO
Do you have frequent headaches?		
Do you clinch or grind your teeth?		
Do you bite your lips/cheeks frequently?		
Have you ever had any difficulty with extractions in the past?		
Have you ever had any prolonged bleeding following extractions?		
Have you had any orthodontic treatment?		
Do you wear dentures or partials?		
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth & gums?		

Authorization and Release

I certify that 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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVEW IS CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.
As required by "HIPAA", we have prepared this explanation of how we required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

***TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

***PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

***HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.
We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
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 used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care 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 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 health care 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 _____

FOR OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgment on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason:** _____

5683 HIGHWAY 311
HOUMA, LA 70360

Stephen A. Morgan Jr DDS
Lauri Daigle DDS
Priya Patel DDS

HOUMA FAMILY DENTAL

PHONE: (985) 868-5699
FAX: (985) 223-4221

Ross M. Cascio DDS
Rachael M. Marcello DDS

ASSIGNMENT OF BENEFITS FORM

I, _____, understand that services rendered to me by **Houma Family Dental** are my financial responsibility and that the provider will bill my insurance company _____ (insert insurance company name), as a courtesy. I authorize my insurance company to pay my benefits directly to **Houma Family Dental** and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Houma Family Dental** within 48 hours. I agree that if I fail to send the payment to **Houma Family Dental** and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize **Houma Family Dental** to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize **Houma Family Dental** to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Signature of Patient/Guardian _____ Date _____

Signature of Policy Holder _____ Date _____

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ACCOMPANY PATIENT FORM

In the event that I (parent or legal guardian), am unavailable to accompany my child to their appointment, I give the following people permission to accompany him/her, sign any paperwork needed, and/or authorize any dental treatment necessary.

PLEASE LIST NAME AND CONTACT NUMBER FOR EACH PERSON

1. _____

2. _____

3. _____

4. _____

5. _____

In the event I must be contacted, I can be reached at: _____.
(phone/cell number)

_____ **By checking this box, I wish to not let anyone accompany my child to his/her appointment except for myself (parent or legal guardian).**

Signature of Parent/Guardian _____ Date _____

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CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthesia agent, analgesic agent(s) to produce conscious sedation and/or premedication prior to dental care being rendered. Some of these risks/complications are, but are not limited to the following:

Infection	Failure of treatment to accomplish main purpose
Bleeding	Trismus (jaw pain or difficulty opening mouth)
Failure of wound to heal	Breakage of root(s) and retained root fragments and/or aspiration of objects
Loss of bone	Opening between mouth and sinus or mouth and nose
Instrument breakage	Injuries to adjacent teeth and/or hard soft tissue
Bacterial endocarditis	Swallowing
Loss of teeth	Dry Socket
Incomplete removal of tooth	Injury to adjacent structures
Allergic reaction to drugs	Tooth or fragment in maxillary sinus
Death (in rare instances)	Paresthesia or numbness of tongue and/or mouth/face
Fracture of mandible or maxilla	Slough (unanticipated loss of hard and/or soft tissue)

Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s).

ACKNOWLEDGMENT

I acknowledge that I have read this consent form, or that is has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions were answered to my satisfaction.
I hereby authorize and direct the dentist and/or associates, hygienist, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writing.

Signature of Patient/Guardian _____ Date _____