Hebert FAMILY DENTISTRY
RYAN P. HEBERT, DDS 337-233-1271

ABOUT YOU

Today's Date:____________

Patients Name:____________________

What you prefer to be called:____________

___Male ___Female

Birthdate: _______ Age: ____

SS#:____________

Mailing Address: ____________________

(city)____________ (state)____ (zip)______

Home Phone # (____)____________

Work Phone # (____)____________

Cell Phone # (____)____________

E-mail Address: _________________

Referred By: ____________________

Employer:____________How Long?____

Employers Address:________________

(city)__________(state)____ (zip)_________

Occupation: ____________________

Status: __minor __single __married
__divorced __separated __widowed

Spouse's Name: ____________________

Do you have children? __yes __no
How many?_______

ACCOUNT INFO

Person ultimately responsible for account:

Name: ________________________

Relation:______________________

Billing address:________________

(city)__________**(state)**_____**(zip)**______

SS#______________

Work Phone #: (____)______________

initials:_____ **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand i am solely responsible for any balance not paid by my insurance company (if offered at this office)**

INSURANCE INFO

Primary Dental Ins

Co. Name: ______________________

Address: ________________________

(city):__________(state)____(zip)_______

Phone # (____)____________

Insured's ID#:_________________

Group#: (plan, Local, or Policy #):

____

Insured's Name: _________________

Relation: _________ DOB: _________

Insured's employer: _________________

Secondary Dental Ins

Co. Name: ______________________

Address: ________________________

(city):__________(state)____(zip)_______

Phone # (____)____________

Insured's ID#:_________________

Group#: (plan, Local, or Policy #):

____

Insured's Name: _________________

Relation: _________ DOB: _________

Insured's employer: _________________

Please read and sign:

- We invite you to discuss any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient
- **Our policy requires payment in full for all services rendered at the time of visit**, unless other arrangements have been made with the business manager. I**f account is not paid within 90 days of the date of service** and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- **If account is not paid within 30 days of the date of service, you will be responsible for a $50 late fee.**
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release my information required to make insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Date: _________

Signature: ________________________

__patient __parent or guardian __spouse

DENTAL INFO

Reason for Today's visit: ___ Exam ___ Emergency ___ Consultation
Are you in pain? ___ NO ___ YES How long? ___________________

Please indicate any of the following problems:

__ Discomfort, clicking or popping in jaw
__ Red, swollen or bleeding gums
__ Sensitive tooth, teeth or gums
__ Blisters/Sores in or around the mouth
__ Lost/broken fillings
__ Teeth grinding
__ Ringing in ears
__ Broken/chipped tooth
__ Stained teeth
__ Locking Jaw
__ Bad Breath
__ Other: ____

Do you require pre-medication? __ YES __ NO __Don't know

Previous Dentist: ________________________________ Phone#: (____)______________
Last dental exam: ______________ Last Dental x-rays: ________________
Times a day you brush? _____________ Times a week you floss? _________________
What type of toothbrush bristles do you use? __Soft __Medium __Hard
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

What medications are you taking?____

____

Have you ever taken: Bisphosphonates (ex: Aredia/Fosamax) __YES __NO
Phen-fen/Redux __YES __NO

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Angina
Y N Valvular Defect
Y N Rheumatic fever
Y N Low Blood pressure
Y N High Blood pressure
Y N Arthritis
Y N Diabetes
Y N MAO inhibitors
Y N Liver Problems
Y N Lupus
Y N Multiple Sclerosis
Y N STDs
Y N Herpes
Y N Heart Attack
Y N Heart Surgery
Y N Pacemaker
Y N Asthma
Y N Anemia
Y N Birth control
Y N Emphysema
Y N Glaucoma
Y N Kidney Problems
Y N HIV / AIDS
Y N Epilepsy / Seizures

Please list any other surgeries or medical conditions you have or ever had:

____

Do you use tobacco? __NO __YES/How used? ________ How much? ______ How long? _____

Are you allergic to any of the following? __Latex __Penicillin/Amoxicillin __Tetracycline __Aspirin
__Dental Anesthetics __Foods:______________________________
__Others:____________________

For Women: Are you taking birth control pills? __YES __NO
How many children have you had? _____
Are you Pregnant? __NO __YES / How long? _______ Are you Nursing? __NO __YES

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

Signature: ____ Date: __________________

___Adult Patient ___Parent or Guardian ___Spouse

No-Show Policy

In fairness to other patients and our staff, we require at least a 24 hour notice prior to canceling an appointment. Should you miss an appointment without giving our office a 24 hour notice, you may be subject to a no-show fee of **$150.00**.

Please sign below acknowledging that you understand Hebert Family Dentistry's no-show policy.

Name (printed): ________________________________ Date: _______________

Signature: _________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I ____have received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Sign: ____

Date: ____________________________

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I,_____________________________ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

For 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

___Communications barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (Please Specify) ____

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