SANDERS DENTAL GROUP
SAMUEL H. SANDERS ~ DAVID DESONIER
MICHAEL BOUDREAUX

WWW.SNDDENTAL.COM
Tel: 985-876-5430

761 WEST TUNNEL BLVD. STE. A
HOUMA, LA 70360

PATIENT INFORMATION

Date: ☐ NEW PATIENT ☐ UPDATE

Patient:

LAST | FIRST | MI | PREFERRED | TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)
CUSTODY ISSUES-PLEASE LIST

**IF STUDENT, PLEASE COMPLETE: ☐ FULL-TIME ☐ PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: **Patient SSN:**

Address: C/O

MAILING ADDRESS

CITY | STATE | ZIP CODE

HOME:
WORK:
CELL:
OTHER:

E-Mail:

Referral? ☐ Yes ☐ No Referred by:

MEDICAL HISTORY UPDATES

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Would you like to have a VisiLite oral cancer screening? ☐ Y ☐ N
**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y ☐N Under a physician's care now?
☐Y ☐N Any hospitalization in the past 5 years?
☐Y ☐N Any serious illnesses/surgeries?
☐Y ☐N Use tobacco in any form? If Yes, Type:
☐Y ☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

Turn Over & FILL OUT OTHER SIDE

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ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ ACID REFLUX
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER'S
- ☐ BLEEDING DISORDER
- ☐ BULIMIA
- ☐ CANCER/MALIGNANCY
- ☐ CEREBRAL PALSY
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX
- ☐ CONVULSIONS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS/FAINTING
- ☐ EPILEPSY/SEIZURES
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT HEADACHES
- ☐ HEARING PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ MITRAL VALVE PROLAPSE
- ☐ MONONUCLEOSIS
- ☐ PACEMAKER
- ☐ OTHER – PLEASE LIST:
- ☐ PSYCHIATRIC TREATMENT
- ☐ RADIATION/CHEMO
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID CONDITION
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

MEDICAL HISTORY / ALLERGIES / ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- ☐ ASPIRIN
- ☐ ANESTHETIC – LOCAL
- ☐ BARBITURATES
- ☐ OTHER – PLEASE LIST
- ☐ CODEINE
- ☐ DAIRY
- ☐ LATEX
- ☐ LACTOSE INTOLERANCE
- ☐ METAL SENSITIVITY
- ☐ NITROUS OXIDE SEDATION
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ PENICILLIN/OTHER ANTIBIOTICS
- ☐ NONE

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ ANTIBIOTICS/SULFA DRUGS
- ☐ BLOOD THINNERS
- ☐ INSULIN
- ☐ RECREATIONAL DRUGS
- ☐ OTC DRUGS/ MEDICATIONS
- ☐ ANTIHISTAMINES/ALLERGY
- ☐ CANCER/CHEMO MEDICATIONS
- ☐ NITROGLYCERIN
- ☐ THYROID MEDICATIONS
- ☐ OTHER (PLEASE LIST BELOW)
- ☐ DAILY ASPIRIN
- ☐ CORTISONE/STEROIDS
- ☐ ORAL CONTRACEPTIVES
- ☐ TRANQUILIZERS
- ☐ BLOOD PRESSURE MEDICATIONS
- ☐ HEART MEDICATION/DIGITALIS
- ☐ OSTEOPOROSIS MEDICATIONS
- ☐ OTHER DIABETIC MEDICATIONS

(PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: DATE:

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

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DENTAL INSURANCE

Insurance Co. _____ Employer _____

Subscriber Name _____ Subscriber Birthdate _____

Subscriber SS# _____

Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will extend to future insurance companies and will end two years from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date **Relationship to Patient**

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT 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 need. Any alternatives to the recommended treatment, including no treatment, have been explained to me in general terms.
Hygiene: prophy, exams, x-rays, full mouth debridement, scaling and root planning
Operative: crown, onlays, inlays, bridge preps, occlusal adjustments, splint adjustments, fillings
Surgery: simple extractions, surgical extractions, bone contouring, gingival contouring
Prosthodontics: complete dentures, partial dentures

I understand dentistry is not an exact science and complications may occur despite a dentist's best effort. There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation and/or pre-medication prior to dental care being rendered.

***Some of the risks/complications are (but not limited to) the following:**
Sensitive to temperature, Damage, fracture or possible loss of tooth being treated as well as adjacent teeth and bone, Failure of wound to heal, Injuries to adjacent teeth and or soft tissue, Paresthesia (numbness of tongue), mouth, and/or face. Fracture of the maxilla (upper jaw) or the mandible (lower jaw), Opening between mouth and sinus or mouth and nose, Sloughing (unanticipated loss of hard and/or soft tissue), Trismus (jaw pain or difficulty opening), Additional surgery, hospitalization and/or further treatment may be required, burns from chemical agents used in treatment, Loss of or damage to the ability to taste, speak and/or see, Breakage of root(s) and retained root fragments, Damage to or loss of filling or other dental work, Change in bite, Incomplete removal of tooth, loss of tooth/teeth or bone, Dry socket, Injury to adjacent structures, Instrument breakage, Allergic reaction to drugs or anesthetics, Bacterial Endocarditis (heart infection), Failure of treatment to accomplish its purpose, TMJ dysfunction or worsening TMJ condition, Injury from airborne particles or instruments, Infection, Bleeding, Tooth or fragment in maxillary sinus.

State Law also requires that we specifically advise you, although rarely occurring, that dental treatment or anesthetic use may result in: Paraplegia (paralysis of both legs), Quadriplegia (paralysis of both legs and arms), Loss of function of organ(s) or limb(s), Brain damage, or Death.

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE READ, OR THAT IT HAS BEEN READ TO ME, AND I UNDERSTAND THE INFORMATION CONTAINED ON THIS CONSENT FORM. I WAS GIVEN OPPORTUNITY TO ASK QUESTIONS THAT WERE ANSWERED TO MY SATISFACTION. I HEREBY AUTHORIZE AND DIRECT THE DENTIST AND/OR ASSOCIATES, HYGIENIST, ASSISTANTS OF THEIR CHOICE TO PERFORM DIAGNOSTIC, SURGICAL, OR DENTAL TREATMENT. THIS CONSENT WILL REMAIN VALID UNTIL REVOKED BY ME IN WRITING.

Patient Name: _____ Parent/Guardian (Print) _____

Relationship to Patient: _____ Signature: _____

Date: _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name: _____ **Date:** _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER(PLEASE EXPLAIN)

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by the doctors or staff of **SANDERS DENTAL GROUP** :

☐ Cell phone: ☐ Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

I give permission for **Sanders Dental Group** to disclose their identity when calling; to anyone who may answer my phone. ☐Y ☐N ☐ Other (Please explain)

I grant permission for **Sanders Dental Group** to leave a message on:

☐ Home phone ☐ Work Phone
☐ Cell Phone ☐ With any person who may answer when calling the home or cell phone
☐ None of the above (Please explain)

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

OFFICE POLICIES

- **Parents MUST remain in the waiting area while your child is in the treatment room.**
- **We require 24 hour notice in the event that you/your child cannot keep a scheduled appointment.**
- **Less than 24 hour notice for a cancellation will result in a missed/broken appointment.**
- **After 2 missed/broken appointments, we will no longer treat you/your child at this facility.**
- **Please provide updated phone numbers and address in order for us to contact you for appointments.**

Patient Name: _____ Parent/Guardian (Print) _____

Relationship to Patient: _____ Signature: _____

Date: _____