



LOUISIANA ORAL & IMPLANT SURGERY

Today's Date 09/20/2022

PATIENT INFORMATION:

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____

Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No

Referred By _____ Has a family member ever been a patient of our practice? Yes No

Dentist _____ Orthodontist _____

Medical Dr. _____ Preferred Pharmacy _____ Tel. (_____) _____

Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Self (If self, skip this section) Spouse Father Mother Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____

Tel. (_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel. (_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name _____ Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION:

Student: Full Time Part Time Not School Name and Address _____

Marital Status: . Married Divorced Widowed Single Legally Separated _____

Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Tel. (_____) _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ Birth Date _____ Sex: M F

S.S. # _____ Tel. (_____) _____

Address _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Tel. (_____) _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ Birth Date _____ Sex: M F

S.S. # _____ Tel. (_____) _____

Address _____

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Tel. (_____) _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ Birth Date _____ Sex: M F

S.S. # _____ Tel. (_____) _____

Address _____

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____

Tel. (_____) _____ Group Name _____

Group # _____ Insured Party _____

Relation _____ Birth Date _____ Sex: M F

S.S. # _____ Tel. (_____) _____

Address _____

HEART PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Heart attack		
Chest pain / angina		
High blood pressure		
Prosthetic heart valve		
Congestive heart failure (CHF)		
Heart bypass surgery (CABG)		
Heart stents		
Congenital heart defect		
Pacemaker / defibrillator (ICD)		
Infective endocarditis		
Heart palpitations		
Irregular heart beat (arrhythmia)		
Rheumatic fever / heart disease		

BREATHING / LUNG PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Asthma		
COPD		
Sleep apnea (OSA)		
Shortness of breath		
Bronchitis / emphysema		
Tuberculosis		
Cough		

BLEEDING PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Bleeding disorders		
Blood thinners (e.g. coumadin)		
Sickle cell disease		
HIV / AIDS		
Easy bruising		

HEAD / EYES / NOSE / THROAT PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Headaches		
TMJ clicking or pain		
Glaucoma		
Sinus / nasal problems		

LIVER / DIGESTIVE PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Liver disease		
GERD / acid reflux		
Liver cirrhosis		
Hepatitis / jaundice		

ENDOCRINE PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Diabetes		
Thyroid disease		

NERVOUS SYSTEMS PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Stroke / TIA (mini stroke)		
Seizures / epilepsy		
Neuropathy / nerve pain		
Tingling / numbness		
Cerebral palsy		
Fainting spells		

MENTAL HEALTH

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Eating disorder		
Emotional disorder		
Dementia		
Depression		
Anxiety / panic disorder		

JOINT / BONE PROBLEMS

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Arthritis		
Joint replacement (e.g. hip, knee)		
Osteoporosis		

KIDNEY

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Kidney disease		
Kidney failure		
Dialysis		

OTHER (IMPORTANT)

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
History of radiation treatment		
Cancer / tumors		
Chemotherapy		

WOMEN ONLY

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Pregnancy / chance of pregnancy		
Breastfeeding		

SUBSTANCE

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
Tobacco use		
Alcoholic beverages		
Recreational (street) drugs		

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____ X _____
Signature of patient (Parent or Guardian if Minor) Date Reviewed by Date

FINANCIAL POLICY

The following is a detailed description of our financial policy. Please read carefully:

- As any legitimate business endeavour, we expect to be fully reimbursed for 100% of the agreed upon fees for the services we render.
- We promise to be clear and unambiguous regarding fees and your financial responsibility before treatment.
- We reserve the right to collect payment before services are rendered.
- **Our full fee is due at the time of service rendered in all cases unless prior arrangements have been made.**
- We accept cash, check, Visa, MasterCard, Discover, and American Express.
- We also offer financing options for our patients through Care Credit.
- **Louisiana Oral & Implant Surgery does not participate with any dental or medical insurance plan (including Medicare/Medicaid).**
- Please remember that you are fully responsible for all fees charged by our office at the time of service regardless of your insurance coverage.
- **Even if you have dental or medical insurance, 100% of fees are due from the patient at the time of service.**
 - *As a courtesy to patients, we will file / submit your claim to your insurance company for you for direct reimbursement to you, the patient.*
 - *We will do so in a timely manner, and in a way that maximizes reimbursement to you.*
 - *Not all services are a covered benefit. Benefits will vary on different insurance plans. It is your responsibility to verify your insurance coverage.*
- All unpaid charges accrue 10% per week finance charge.
- Delinquent accounts are defined as remaining balances that do not comply with the agreement stated here or accounts that have incorrect or no forwarding address.
- All delinquent accounts will be reported to credit bureaus which will reflect on your credit score.
- The following fees are added to delinquent accounts:
 - 1) \$30.00 service charge for accounts sent to Credit Bureau
 - 2) All attorney, court, and miscellaneous collection costs
- **We understand that temporary financial problems may affect your ability to make timely payments on your account. We ask that you contact us if you encounter such problems so that we may assist you in the management of your account.**

We appreciate your trust and the opportunity to serve you. If you have any questions or need assistance regarding your account, please contact our office at (337)-888-4771.

By signing below, you acknowledge that you have carefully read and understand this Financial Policy, and agree to all of its conditions. You also agree to be responsible for payment of all services rendered on behalf of dependents.

X _____ X _____
Signature of patient (Parent or Guardian if Minor) Date

FEES & PAYMENTS

We make every effort to provide the highest quality care at the most reasonable cost. Payment in full is due at the time of services rendered unless other arrangements have been made in advance. By signing below, you acknowledge that you have read, understand, and agree to abide by the Louisiana Oral & Implant Surgery financial policy.

X _____ X _____
Signature of patient (Parent or Guardian if Minor) Date

CONSENT FOR ROUTINE MEDICAL TREATMENT

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X _____ X _____ X _____
Signature of patient (Parent or Guardian if Minor) Doctor Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Louisiana Oral & Implant Surgery is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgement. The Notice is posted on our website (www.LouisianaOIS.com) and throughout our office. You will be given a copy for your personal use.

Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement. If terms of our Notice change, a revised copy will be made available to you.

By signing, you acknowledge that you have been provided a copy of Louisiana Oral & Implant Surgery's Notice of Privacy Practices (also available online at www.LouisianaOIS.com) with an effective date of 07/01/2019.

By signing below, you acknowledge that our practice may use and disclose protected health information about you for treatment, payment and healthcare operations as well as all other uses described in the Notice of Privacy Practices.

My signature below acknowledges that I have read and agree to the terms of the Notice of Privacy Practices.

X _____ X _____
Signature of patient (Parent or Guardian if Minor) Date