LSU FACULTY DENTAL PRACTICE

PATIENT REGISTRATION

Date: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: (____) _____ Work: (____) _____ Other: (____) _____

Sex: ___ Male ___ Female Date of Birth: _____ Age: ____

Social Security #: _____

Did a doctor refer you to the practice? Who? _____ Telephone: (____) _____

Marital Status: _____ Employer: _____

Emergency Contact Name: _____ Phone Number: _____

Primary Physician: _____ Telephone: (____) _____

Has a member of your family been seen in our practice? Who? _____

I certify that the information on this form is correct, and I understand that I am responsible for any balance on this account.

Signature of Patient or Responsible Party: _____

LSU FACULTY DENTAL PRACTICE

MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills? ..... Yes No
   If so, please list:_____
8. Do you use any tobacco products? ..... Yes No
   If so, what kind and how often?_____
   Are you interested in a smoking cessation program? ..... Yes No
9. Do you drink alcohol? ..... Yes No
   If so, how many drinks per week?_____
10. Do you use any recreational drugs? ..... Yes No
11. Do you have or have you had any of the following diseases or problems?

Damaged heart valves, artificial valves, heart murmur or pacemaker	Y	N	Hepatitis, jaundice or liver disease	Y	N
Rheumatic heart disease	Y	N	Frequent or recurring mouth sores	Y	N
Heart trouble, heart attack, angina , arteriosclerosis or any other heart condition	Y	N	Thyroid problems	Y	N
Chest pain upon exertion	Y	N	Respiratory problems, emphysema, bronchitis, etc	Y	N
Shortness of breath after mild exercise	Y	N	Stroke	Y	N
Do your ankles swell	Y	N	Stomach ulcer or hyperacidity	Y	N
Allergies	Y	N	Kidney trouble	Y	N
Sinus trouble	Y	N	Tuberculosis	Y	N
Asthma or hay fever	Y	N	Persistent cough or cough that produces blood	Y	N
Fainting spells or seizures	Y	N	Persistent swollen neck glands	Y	N
Diabetes	Y	N	High or Low blood pressure	Y	N
Cancer	Y	N	Epilepsy or neurological disorder	Y	N
Any disease, drug or transplant operation that has depressec your immune system	Y	N	Arthritis; Painful, swollen joints including jaw joint (TMJ)	Y	N

12. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
13. Do you have any blood disorder such as anemia? ..... Yes No
14. Have you ever had treatment for a tumor or growth? ..... Yes No

15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other ..... Yes No

16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
18. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel for osteoporosis, chemotherapy for multiple myeloma, etc.) ? ..... Yes No
19. Are you wearing removable dental appliances? ..... Yes No
20. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women:

21. Are you pregnant or trying to become pregnant? ..... Yes No
22. Are you nursing? ..... Yes No
23. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint: _____
_____
_____

I certify that I have read and understand the 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 dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature: _____

Office Use

Medical History Update:

Date	Comments	Signature

LSU FACULTY DENTAL PRACTICE

FINANCIAL POLICY

- Full payment is expected at the time of service. Payment can be made by cash, check, or credit card (Visa/MC).

- The Practice offers a 3rd party financing option, Care Credit, for qualifying applicants with procedure costs above $500. Alert the business office if you are interested in further information.

- **WE DO NOT ACCEPT INSURANCE.**
  Upon request, we can provide the patient/guarantor with the information needed to file a claim for personal reimbursement.

- All returned checks will incur a $25 charge and this amount will be added to your account balance.

- Upon completion of treatment, any account remaining unpaid after 3 months will be forwarded to the collection agency.

- In the event of an overpayment, a refund will be promptly issued to the person listed as the guarantor on the account.

By signing this document, you agree to the payment terms as described above.

Patient / Guarantor: _____ **Date:** _____

LSU Faculty Dental Practice

Consent For Treatment

I hereby authorize the dental practitioners of LSU Faculty Dental Practice or personnel authorized by them to:

1. Perform those procedures necessary to complete treatment.
2. Perform treatment, procedures or tests differing from the original treatment plan that may arise from unforeseen conditions which the practitioner considers necessary or advisable during the course of treatment.
3. Obtain medical information and/ or reports from my medical doctor in order to facilitate my diagnosis and treatment.
4. Use local anesthesia, analgesia sedation and/ or general anesthesia.
5. Perform surgical procedures in or around the mouth.
6. Use and dispose of any tissue or parts which are removed.
7. Take and use photographs, materials, tissues and records pertinent to my case for the purposes of teaching, research and scientific publications.

I certify that I have read and fully understand the terms of the consent above.

Signature of Patient, Parent, or Guardian: _____

Witness: _____

Date: _____