Dr. John C. Moreau and Associates

3820 Masonic Dr. Service Road
Alexandria LA 71301
318-442-9555
Alexandriadentalpractice.com

Date____/____/____ PRIMARY LANGUAGE SPOKEN_____

Patient: Last_____First_____MI_____

Home Phone ( )_____Work ( )_____Cell Phone ( )_____

Home Address_____City_____State_____Zip_____

Mailing address_____City_____State_____Zip_____

Email Address_____

Patient Social Security #_____-_____-_____ DOB_____/_____/_____ Age_____

Sex_____ Marital Status_____Spouse's Name_____

Responsible Party if different from Patient

Father/Guardian: Last Name_____First Name_____

Father/Guardian: Address_____

Email address_____

Home/cell phone _____Work phone_____

Mother/Guardian: Last Name_____First Name_____

Mother/Guardian: Address_____

Email address_____

Home/cell phone _____Work phone_____

In case of an Emergency, Contact (please specify someone who does not live in your household.)

Name _____Relationship to patient_____

Address_____City_____State_____Zip_____

Home/cell phone (_____)_____Work phone (_____)_____

Who may we thank for referring you?_____

(Patient, Doctor, Website, Sign, Walk-in, Etc.)

Please fill this form out COMPLETELY.

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized or had surgery? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Blood Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychiatric Therapy	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Barbiturates (any)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Do you use recreational drugs?____ If so, which ones? _____

Sleep:

1. Do you suspect or have you been told that you snore?
2. Do you suspect or have you been diagnosed with sleep apnea?
3. Are you being treated for sleep apnea with a CPAP, BiPAP, or other device?

Women: Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes
Abnormal Blood Pressure? (Please circle)	No	Yes

Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"?

What is your normal blood pressure? S/D _____ Toda? : _____/_____

Are you allergic to or have you had a reaction to any of the following? **Please circle**

a.	Local anesthetics or epinephrine.....	No	Yes
b.	Penicillin or other antibiotics	No	Yes
c.	Aspirin, Ibuprofen or Tylenol®	No	Yes
d.	Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives.....	No	Yes
e.	Latex or Metals		
f.	Other (please specify)_____		

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? _____	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Height	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none* *slight* *moderate* *high*				

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)	*Patient Signature*	*Date*
Doctor (Print Name)	*Doctor Signature*	*Date*

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE

DATE: _____

PATIENT NAME (PLEASE PRINT): _____

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE: _____

Patient Cancellation & Missed Appointment Policy

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

If you need to reschedule or cancel an appointment, we require a **minimum of 48 hours notice.**
Please call the office at (318) 442-9555.

"Missed Appointments" or last minute cancellations also leave empty appointment times, as well as other patients waiting to receive dental care. For that reason, patients that do not notify the office of a cancellation and are not present for their scheduled appointment will be charged a cancellation fee as follows:

Less than 48 hours notice and Missed Appointment:
$50.00

We realize that on rare occasion, emergencies may arise and we will address these situations with you at that time. Also, if there are any changes in phone numbers, please contact our office with these changes so we may confirm your future appointments. If we can't confirm your appointment the day prior to the scheduled appointment, you risk losing the appointment.
We thank you for working with us to ensure services are provided to you in the best possible way.

ACKNOWLEDGEMENT OF CANCELLATION & NO SHOW POLICY

Your signature on this document indicates your understanding and acceptance of our policy regarding cancellation and/or missed appointment. If you should have any questions regarding this policy, Dr. Moreau's office will be happy to discuss them with you.

Patient Name: _____

Signature: _____

Date: _____

UNFORGETTABLE SMILES
DR. JOHN MOREAU AND ASSOCIATES

PATIENT PREFERENCE FORM

Patient Name: _____ **Date:** _____

At Unforgettable Smiles our mission is to make your visit with us like no other dental visit you have ever experienced. It is part of our patient centric philosophy, where your convenience and comfort are a primary concern. Please fill out your preferences below so we can better serve you.

Best days and times for the Doctor to treat you. Please circle days and times you prefer.

M	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
TU	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
W	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
TH	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
F	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm

Best days and times for the Hygienist to treat you (cleaning). Please circle days and times you prefer.

M	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
TU	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
W	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
TH	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm
F	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm

What is your apprehension Level 1-10 with 1 being calm and 10 being very nervous? _____

We offer the following sedation options to insure your complete comfort during your dental treatment visit: Please circle your preference

Nitrous Oxide: Commonly known as laughing gas, this is a safe and effective technique to reduce anxiety. The right dosage will make you feel euphoric, lightheaded, tingling and warm. You are perfectly safe to drive after using nitrous oxide.

Oral Sedation: We'll give you a prescription for a sedative to take the night before your first appointment to guarantee a good night's sleep and to make sure you wake up relaxed. Your companion will bring you to the office. Additional medications will be provided to take the morning of your appointment to create the ultimate in relaxation. Your experienced sedation team will monitor you throughout your entire visit.

IV Sedation: Intravenous sedation is an option that allows dental procedures to be performed while you are under the influence of a sedative drug that is administered through a vein. You are in an induced, highly relaxed sleep - like state. An anesthesia professional is present during the entire procedure to monitor your progress. When you "wake up" you will not remember anything about the entire procedure, will feel no pain during the procedure and will feel like no time has passed.

Is there anything else we can do for you to make your visit with us 5 star?

_____

_____

_____

_____

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Insurance and Financial Policy

As a service to our patients, we are glad to accept payment directly from your insurance company. However, we ask that you realize that we do NOT work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge WILL ALWAYS BE BASED YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE."

Co-payments and any deductibles are due and payable upon date of service. Should financial arrangements be needed, we will be happy to discuss options with you.

Please read and sign this statement in agreement of our policy of accepting payment from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim. We will be happy to answer any questions you may have.

I hereby authorize payment directly to Dr John C. Moreau Jr DDS and/or Associates, insurance benefits otherwise payable to me.

I authorize release of any information relating to my treatment to the group insurance carrier.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 45 days, I will be responsible for the full amount owed to Dr. John C. Moreau Jr DDS and Associates.

I understand that after my insurance company pays, there could still be a remaining balance, which is payable in full, by me, upon receipt of a billing statement.

_____ _____

Signature of Responsible Party Date

IF THERE IS NO INSURANCE COVERAGE:

I understand and agree that I am responsible for the payment of all treatment fees on my account, payable upon date of service.

_____ _____

Signature of Responsible Party Date