Welcome . . .

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we can communicate, the better we can care for you. ~ Dr. Perry's Office

Patient Information for

Patient Information for ______________________________ Date of Birth : _____/_______/______

Social Security #: ______________________ Email Address: ____________________________

Mailing Address: ______________________________ City: ____________State:_____ Zip:__________

Sex: ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Minor

Employer/School: ____ How many years? __________

Employer/School address: ____

Occupation: ____________________________ Employer/School phone #: ________________

Whom may we thank for referring you? ____

Other family members seen by us: ____

Phone Numbers

Home: (_______) __________________ Work: (_______) __________________ Cell: (_______) __________________

How would you like to confirm your appointments? Phone call ☐ Email ☐ Text Message ☐

Alternate/Emergency Contacts

Primary Contact Name: ________________________ Relationship: ____________ Phone #: ____________

Secondary Contact Name: ______________________ Relationship: ____________ Phone #: ____________

*****Please provide the name of someone who does NOT live in your household and who has a phone number different from yours.**

Responsible Party Information

Who is responsible for this account?

Name: ____

Relationship: __________________________________

Social Security #: ______________________________

Address: ______________________________________

City: _______________ State: ________ Zip: __________

Phone: Home#: (____)_______________

Work #: (____)_______________

Cell #: (____)_______________

By signing below, I acknowledge that the information above is true to the best of my knowledge and that I am financially responsible for all charges whether or not paid by the patient's insurance carrier.

Signature: ____________________________________

Date: ________________

Primary Dental Insurance

Insurance Company:____________________

Subscriber id#: ____________________

Employer: ____________________

Group#:__________ Phone#: ____________

Subscriber Information:

Name: ____________________________

Relation: __________________________

Birthdate: ____/____/_____ SS#:__________

I authorize the use of my signature on all insurance submissions.

Signature:____________________________

Secondary Dental Insurance

Insurance Company:____________________

Subscriber id#: ____________________

Employer: ____________________

Group#:__________ Phone#: ____________

Subscriber Information:

Name: ____________________________

Relation: __________________________

Birthdate: ____/____/_____ SS#:__________

I authorize the use of my signature on all insurance submissions.

Signature: ____________________________

Health History

What brings you in to see the dentist today?___________________________

Are you currently in pain? □ No □ Yes How Long?___________________

Who is your previous dentist? _____________________________________

Have you ever had a problem with previous dental work? □ Yes □ No

If yes, explain: ____

When was your last Dental Exam? _________ Last Dental X-rays?_________

Times a Day you brush? _______ Times a Week you floss? _____

Please check any of the following problems:

□ Discomfort, clicking or popping in jaw
□ Red, swollen, or bleeding gums
□ Sensitive Teeth
□ Broken/ Chipped Teeth
□ Other____
□ Lost/Broken Fillings
□ Teeth Grinding
□ Bad Breath
□ Stained/Discolored Teeth

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature **Date**

Payment is due at time of service unless prior arrangements have been made with the office.

Are you currently under the care of a physician? □ Yes □ No
Please Explain: ____
Do you smoke or use tobacco in any form? □ Yes □ No
Do you have or have you ever had any of the following diseases or medical conditions?

Y N Heart Attack/Stroke
Y N Heart Surgery
Y N Heart Murmur
Y N Heart Disease
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Artificial Bones/Joints
Y N High/Low Blood Pressure
Y N Congenital Heart Defect
Y N Kidney Problems
Y N Pacemaker
Y N Respiratory Problem
Y N Ulcer
Y N Psychiatric Problems
Y N Venereal Disease
Y N Tuberculosis TB
Y N Scarlet Fever
Y N Back Problems
Y N Fever Blisters/Herpes
Y N Cancer/Tumor
Y N Asthma
Y N Hepatitis Type ___
Y N HIV+AIDS
Y N Anemia
Y N Emphysema
Y N Glaucoma
Y N Chest Pain
Y N Fainting
Y N Shingles
Y N Chemotherapy
Y N Sinus Problems
Y N Diabetes
Y N Leukemia
Y N Arthritis/Rheumatism
Y N Frequent Neck Pain
Y N Severe Headaches
Y N Seizures/Epilepsy
Y N Chemical Dependency
Y N Jaw Problems TMJ/TMD

Please list any other medical condition(s) you have or have had: ____________________________

Are you allergic to any of the following?

□ Latex □ Penicillin □ Tetracycline □ Aspirin □ Dental Anesthetics □Sulfa □ Codeine □ Iodine □ Others: ___________

Are you taking any prescription or over-the counter drugs? □ Yes □ No

Please list each one:____

For Women: Are you taking birth control pills? □ Yes □ No
Are you pregnant? □ Yes □ No Week#: _______________
Are you nursing? □ Yes □ No

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charges directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. A service charge of 11/2% per month (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his/her staff, I agree to pay, therefore, the reasonable values of services to said Doctor at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees. I grant my permission to you, or your assigns, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content:

Signed: ____ **Date**: ______________________________

DANIEL M. PERRY, D.D.S.
FAMILY DENTISTRY
4301 LAKE STREET
LAKE CHARLES, LA. 70605
337.478.0812 337.478.7400

Notice of Privacy Practices

By signing below, you acknowledge our Privacy Practices as required by Federal Law for your records. Please notify staff if you would like a printed copy for your records.

____ ____________________
Patient Signature Date

Record Duplication Policy

Should you require copies of x-rays or records during the course of your treatment, we require a 48 hour advance notice and we reserve the right to charge an administrative fee.

Cancellation Policy

We reserve the right to charge a $25.00 cancellation fee for any appointments that are broken without a **24-hour advance** notice. We thank you for your cooperation.

I have read and understand the above policies.

____
Patient Signature Date

A licensed dentist has a professional obligation to provide treatment that he/she feels is in the best interests of the patient. I understand that dentistry is not an exact science and that no specific results can be guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I authorize. As a patient, I acknowledge I do have the right to informed consent regarding my dental treatment and that any treatment plan and fees proposed are subject to modification, depending on unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I acknowledge my right to refuse treatment and understand that any refusal may be contrary to the treatment recommended by my dentist. I also acknowledge that in this event, the dentist is under no obligation to proceed with treatment. I realize that I may reconsider my decision at any time by notifying my dentist.

I have read and understand the above policies.

____
Initials

DANIEL M. PERRY, D.D.S.
FAMILY DENTISTRY
4301 LAKE STREET
LAKE CHARLES, LA. 70605
337.478.0812 337.478.7400

Written Financial Policy

Thank you for choosing the practice of Daniel M. Perry, D.D.S. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment options:

You may choose from these options:

- Cash
- Credit or Debit card (We accept Visa and Mastercard)
- Monthly Payment Plans[1] from CareCredit, which will allow you to pay over time with no annual fees at zero- or low-interest.

Please note:

Our office does require payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of any care already received.

There are times when extensive treatment is necessary for optimal dental health. Many times this treatment requires that we reserve extended appointment times for your care. For advance appointments exceeding one hour, we require a deposit in the amount of $50 for the first hour with $25 for each subsequent half-hour, not to exceed the cost of treatment. This fee will be applied toward treatment upon completion of appointment. If you do not keep your appointment or fail to reschedule 48 hours in advance, this fee is non-refundable.

If you have any questions concerning financial arrangements or our financial policies, please do not hesitate to ask. Your care is of the utmost importance to us, and we want to assist you in getting the care you want and need. Thank you!

[1]CareCredit is subject to credit approval.

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Patient, Parent, or Guardian Signature Date

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Patient, Parent, or Guardian (printed)