Welcome to Our Practice

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us — we will be happy to help.

Dr. Delaune and Staff

Whom may we thank for referring you? _____

ABOUT YOU

Name:_____ I prefer to be called_____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birthdate:____/____/____ Age:_____ Social Security #:_____

Home Address:_____City_____State____ Zip Code_____

Home Phone:(_____)_____ Work:(_____)_____ Ext:_____ Pager:(_____) _____

Cell Phone:(_____)_____ E-mail Address:_____

Employer:_____ How long there?_____ Occupation:_____

Employer's Address:_____City_____State ____ Zip Code_____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name:_____ Birthdate:____/____/____ Relation:_____

Billing Address:_____City_____State____ Zip Code _____

Home Phone:(_____)_____ Work:(_____)_____ Ext:_____Social Security #:_____

Employer:_____ How long there?_____ Occupation:_____

SPOUSE INFORMATION

[ ] Same as above Name:_____ Birthdate:____/____/_____

Employer:_____ Work Phone:(_____)_____ Ext: _____

DENTAL INSURANCE INFORMATION

Primary Insurance:

Insurance Co. Name:_____ Phone:(_____)_____ Group or Policy #:_____

Insured's Name:_____ Insured's Birthdate:____/____/____ Relation:_____

Insured's Social Security #:_____ Insured's Employer:_____

Secondary Insurance:

Insurance Co. Name:_____ Phone:(_____)_____ Group or Policy #:_____

Insured's Name:_____ Insured's Birthdate:____/____/____ Relation:_____

Insured's Social Security #:_____ Insured's Employer:_____

MEDICAL HISTORY INFORMATION

Name of Physician:_____Phone:(_____) _____
Do you have or have you ever had any of the following? Please check those that apply:

[ ] Allergies/Hay Fever	[ ] Emphysema	[ ] Heart Surgery*	[ ] Rheumatism
[ ] Anemia	[ ] Epilepsy or Seizures	[ ] Hepatitis	[ ] Shortness of Breath
[ ] Angina	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Arthritis	[ ] Fainting or Dizziness	[ ] HIV+/AIDS	[ ] Sinus Problems
[ ] Artificial Joints*	[ ] Fever Blisters/Cold Sores	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Heart Valves*	[ ] Frequent Cough	[ ] Liver Problems	[ ] Surgical Shunt*
[ ] Asthma	[ ] Glaucoma	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Cancer	[ ] Heart Disorder (Congenital)*	[ ] Mitral Valve Prolapse*	[ ] Tuberculosis
[ ] Chemical Dependency	[ ] Heart Infection*	[ ] Radiation Treatment	[ ] Ulcers
[ ] Chemotherapy	[ ] Heart Murmur*	[ ] Respiratory Problems	[ ] Venereal Disease
[ ] Diabetes	[ ] Heart Pace Maker*	[ ] Rheumatic Fever*	[ ] Yellow Jaundice

*These conditions may require antibiotic premedication for certain dental procedures.

Yes No

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?

If yes, please explain:_____

[ ] [ ] Are you now under the care of a physician? If yes, please explain:_____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain:_____

[ ] [ ] Are you taking any medications or herbals? If yes, please list:_____

_____

[ ] [ ] Are you allergic to any medications or substances? If yes, please check box below:

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other _____

[ ] [ ] Do you or have you used tobacco? If yes, please explain: _____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking Oral Contraceptives

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

X_____ Date _____
Signature of patient, parent or guardian

MEDICAL UPDATES (for future use)

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Date:	Exceptions:	Patient's Signature:
_____	_____ [ ] None	X _____
_____	_____ [ ] None	X _____
_____	_____ [ ] None	X _____
_____	_____ [ ] None	X _____

DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them achieve the level of dental health that they desire. This begins with a careful diagnosis and personalized treatment plan. We will perform a **comprehensive oral evaluation** of your teeth, gums, jaw joints, bite, and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern. Once all of your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options available. A **personalized written treatment plan** will then be developed to help you achieve the dental health goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions:
(Check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? [ ] **Yes** [ ] **No**
2. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist.
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not** comfortable.
4. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor**.
6. I am interested in a smile analysis and personalized treatment plan to enhance my smile. [ ] **Yes** [ ] **No** [ ] **Maybe**
7. I would say that my main concerns with my dental health are:_____

   _____

8. Please check which statement below best represents the level of dental health you wish to achieve. (It is not uncommon for patients to change their dental health goals over time.)

   [ ] **HEALTH LEVEL I - Emergency Care**
   I am only interested in emergency care for the relief of pain and/or cosmetic embarrassment.
   I am not very interested in thinking about the future of my dental health at this time.

   [ ] **HEALTH LEVEL II - Maintenance Care**
   I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

   [ ] **HEALTH LEVEL III - Comprehensive Care**
   I am interested in comprehensive care to achieve and maintain a higher level of dental health.
   I am concerned about treating the causes of dental diseases, not simply the effects.
   I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

   [ ] **HEALTH LEVEL IV – Comprehensive & Cosmetic Care**
   I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.
   I am concerned about treating the causes of dental diseases, not simply the effects.
   I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

APPOINTMENT POLICY

We value your time, please value ours. Because we recognize the value of your time, you can expect us to see you at your appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Also, please make every effort not to change your scheduled appointments. If you find that you must change an appointment, please provide us at least a **48 hour advance notification** so that we may use our time to accommodate another patient. Broken and missed appointments create scheduling problems for other patients and our practice. An **hourly charge** may be applied for broken and missed appointments without adequate advanced notifications. Thank you for your cooperation in this matter.

FINANCIAL POLICY

- Unless another financial option is pre-arranged, payment in full is due the day of treatment.
- For procedures requiring longer appointment times, 1/3 down is required to reserve the appointment time.

Payment Options

1. For your convenience we accept **Cash, Check, Visa, Master Card and Discover**.
2. A 5% discount is offered for any treatment plan paid in full by cash or check before the first appointment.
3. A 3% discount is offered for any treatment plan paid in full by Visa, MC or Discover before the first appointment.
4. We also offer short and long-term financing through **Care Credit**.

For Patients with Dental Insurance

- As a courtesy, we will accept assignment of your insurance benefits provided we are able to verify current coverage and have received a copy of your insurance card or a signed, completed dental insurance form.
- We will estimate your insurance benefits and will expect your portion of the fee to be paid at each visit. You are responsible for any portion your insurance company does not cover. If for any reason your insurance company pays less than what was estimated you will be responsible for the unpaid balance.
- If your balance is not paid within 30 days of the billing date, a finance charge of 1.5% per month will be applied to your account. In case of default of payment, you will be responsible for any interest on the balance due, together with any collection costs and reasonable attorney's fees incurred in the collection of your account.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Delaune. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Delaune to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health care professionals involved in my care.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Delaune.

Photographs

I authorize Dr. Delaune to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options (as you may be shown photographs for the same reason).

My signature below acknowledges that:

I understand and will comply with the office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Assignment of insurance Benefits** to Dr. Delaune.
I authorize **Photographs** to be taken of me and shown to other patients.
I have received a copy of this office's **Notice of Privacy Practices**.

X_____ Date_____

Signature of patient, parent or guardian