Guidry Family Dentistry
Josh R. Guidry, D.D.S.
Sara R. Guidry, D.D.S.

PATIENT

NAME last ..... first ..... middle ..... MALE FEMALE

DATE OF BIRTH ..... SOCIAL SECURITY # ..... EMAIL .....

ADDRESS ..... city ..... state ..... zip .....

PHONE HOME ..... work ..... cell .....

EMPLOYER ..... IF MINOR, PARENT'S NAME .....

REFERRED BY .....

MAIN CONCERN/REASON FOR VISIT .....

RESPONSIBLE PARTY

NAME last ..... first ..... RELATION TO PATIENT self spouse parent other

ADDRESS ..... city ..... state ..... zip .....

DATE OF BIRTH ..... SOCIAL SECURITY # ..... EMAIL .....

PHONE home ..... work ..... cell .....

IS THIS PERSON CURRENTLY A PATIENT AT THIS OFFICE? **Y** **N**

DENTAL INSURANCE

INSURED'S NAME ..... INSURED'S SOCIAL SECURITY # .....

PLACE OF EMPLOYMENT .....

INSURANCE COMPANY ..... GROUP # .....

INSURED'S DATE OF BIRTH ..... INSURED'S PHONE .....

EMERGENCY

EMERGENCY CONTACT ..... RELATION TO PATIENT ..... PHONE .....

ADDRESS ..... city ..... state ..... zip .....

HEART HEALTH

For the following questions circle Y or N. 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 responses. Our team may ask additional questions concerning your health.

Artificial Heart Valves	**Y**	**N**
A history of infective endocarditic (infection of the heart's inner lining or the heart valves)	**Y**	**N**
A cardiac transplant that developed a problem in a heart valve	**Y**	**N**
Certain specific, serious congenital (present from birth) heart conditions	**Y**	**N**
Unrepaired or incompletely repaired cyanotic congenital heart disease including those with palliative shunts and conduits	**Y**	**N**
A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure.	**Y**	**N**
Any repaired congenital heart defect with residual defect at site or adjacent to site of a prosthetic patch or device	**Y**	**N**

JOINTS

JOINT REPLACEMENT (HIP, KNEE, ETC.?) Y N

If yes, what joint..... when..... surgeon .....

MEDICAL HISTORY

PHYSICIAN.....

ANY MAJOR ILLNESSES Y N if yes, explain .....

Are you pregnant? Y N Are you a nursing mother? Y N Are you taking birth control pills? Y N

Anemia	Y	N	Rheumatic Fever	Y	N
Blood Disorder (specify)	Y	N	Sore/Enlarged Lymph Nodes	Y	N
ADD/ADHD	Y	N	Recurrent Illnesses	Y	N
HIV Positive or AIDS related complex	Y	N	Glaucoma	Y	N
Hepatitis, any form	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Osteoporosis	Y	N
Epilepsy / Seizures	Y	N	Heart (surgery, disease, attack)	Y	N
Fainting of Dizzy Spells	Y	N	Heart Murmur	Y	N
Asthma	Y	N	Heart Stent (when).....	Y	N
Emphysema or Other Respiratory Illnesses	Y	N	Mitral Valve Prolapse	Y	N
Liver Disease (including Jaundice)	Y	N	Abnormal Heart Condition	Y	N
Kidney Disease	Y	N	Cancer or Tumor	Y	N
Venereal Disease	Y	N	Fever blisters / Cold Sores	Y	N
Latex Sensitivity	Y	N	Radiation or Chemotherapy	Y	N
Anxiety or Panic Attacks	Y	N	High Blood Pressure	Y	N
Psychiatric Care / Emotional Problems	Y	N	High Cholesterol	Y	N
Arthritis or Other Inflammatory Disease	Y	N	History of Angina (chest pains)	Y	N
Swelling or Lumps in Mouth	Y	N	Takes Nitroglycerin	Y	N
Complications from Extractions	Y	N			

ARE YOU A SMOKER? Y N if so, how much per day? ..... SMOKELESS TOBACCO? Y N

DENTAL HISTORY

Frequent Headaches?	Y	N	Last Dental Visit.....		
Previous Treatment for Jaw Pain?	Y	N	Previous/Present Ortho Treatment?	Y	N

ALLERGIES

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

Local Anesthetics	Y	N	Penicillin	Y	N
Codeine	Y	N	Other.....	Y	N

MEDICATIONS

PREFERRED PHARMACY .....

Please list any medications you are currently taking (Please include aspirin and/or blood thinners):

1..... 2..... 3.....

4..... 5..... 6.....

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 changes in my health and medication.

PRINT PATIENT'S NAME .....

PATIENT/PARENT SIGNATURE ..... DATE.....

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CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand and we are ready to answer any of your questions of explain anything. Any alternatives to the recommended treatment, including no treatment, have been explained to me. There are risks associated with any dental treatment. This includes the administration of any local anesthetic agent, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but not limited to, the following:

- Infection
- Bleeding
- Failure of wound to heal
- Injuries to adjacent teeth and/or hard or soft tissues
- Paresthesia or prolonged numbness of the tongue, mouth, or face
- Fracture of mandible (lower jaw) and maxilla (upper jaw)
- Opening between mouth and sinus or mouth and nose
- Tooth or fragment in maxillary sinus
- Incomplete removal of teeth
- Dry socket
- Loss of teeth or bone
- Sloughing (unanticipated loss of hard and/or soft tissue)
- Injury to adjacent structures
- Instrument breakage
- Breakage of root(s) and retained root fragments
- Swallowing and/or aspiration of objects
- Allergic reaction to drugs
- Trismus (jaw pain or difficulty opening mouth)
- Failure of treatment to accomplish its purpose
- Death (in rare instances)
- Bacterial Endocarditis
- Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complications

ACKNOWLEDGMENT

I acknowledge that I have read, or that it has been read to me, and understand the information contained in this consent form. I was given and adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction.

I hereby authorize and direct the dentists, associates, hygienists, and/or assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

SIGNATURE of patient or guardian..... DATE .....

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CONSENT OF DISCLOSURE

(For the Usage and/or Disclosure of Protected Health Information)

I hereby consent to Josh R. Guidry D.D.S. and/or Sara R. Guidry D.D.S. and all health care providers furnishing care to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address on the top of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign the consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling us at 985-449-0611.

PRINT NAME OF PATIENT.....

SIGNATURE.....DATE.....

IF YOU ARE SIGNING ON BEHALF OF THE PATIENT PLEASE STATE RELATIONSHIP.....

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WRITTEN FINANCIAL POLICY

Thank you for choosing our office for your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the 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 can choose from:

☐ Cash, Check, Visa, Mastercard, American Express or Discover Card

We offer a 5% courtesy account adjustment to patients who pay for their treatment with cash or check prior to completion of care or treatment plans of $1,000 or more.

☐ Convenient Monthly Payment Plans* from CareCredit

- Allow you to pay over time
- No annual fees or pre-payment penalties

PLEASE NOTE:

Our office requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. **However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.**

Our office charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

SIGNATURE OF PATIENT OR GUARDIAN ..... DATE .....

PATIENT NAME (PLEASE PRINT) .....

*subject to credit approval