DUHON
FAMILY DENTISTRY

Name: _____ Date of Birth: _____

Medical History

Allergies:

Aspirin: Yes No
Codeine: Yes No
Latex: Yes No
Local Anesthetic: Yes No
Penicillin: Yes No
Sulfa: Yes No
List any other allergies: _____

Medical Conditions:

Abnormal (High/Low) Blood Pressure: Yes No

AIDS/HIV: Yes No

Anemia / Bleeding Problems: Yes No

Artificial Heart Valves: Yes No

Blood Disease: Yes No

Congenital Heart Lesions: Yes No

Heart Problems: Yes No

Pacemaker: Yes No

Arthritis / Rheumatism / Gout: Yes No
Artificial Joints / Bones: Yes No

Asthma: Yes No
Cancer: Yes No
Chemotherapy: Yes No
Diabetes: Yes No
Emphysema: Yes No
Glaucoma: Yes No
Radiation Treatment (X-Ray/Cobalt) : Yes No
Shortness of Breath (Breathing Problems) : Yes No
Sinus Trouble: Yes No
Stroke: Yes No
Thyroid Problems: Yes No
Tuberculosis: Yes No
Tumor / growth on head / neck: Yes No
Ulcer: Yes No
Epilepsy: Yes No
Fainting / Dizziness : Yes No
Headaches (Frequent): Yes No
Hepatitis: Yes No
Herpes: Yes No
Kidney Disease: Yes No
Liver Disease: Yes No
Nervous Problems: Yes No
Psychiatric Care: Yes No

List any other medical issues you have_____

List any serious Illnesses / surgeries / hospitalizations_____

List any medications you are taking_____

Pregnant **:** Yes No
Nursing : Yes No

Signature: _____ Date: _____

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Name: _____ Date of Birth: _____

Dental History

Reason for visit_____

Date of last dental visit_____

Date of last dental X-rays_____

How often do you floss_____

How often do you brush_____

Bad Breath_____

Bleeding, Red, Swollen Gums_____

Broken/Loose teeth or fillings_____

Clicking or popping jaw_____

Grinding teeth_____

Pain around ear/side of face_____

Sores/Blisters in mouth_____

List any other dental concerns/pain_____

Signature: _____ Date: _____

3829 Ryan St, Ste 200 Lake Charles, LA 70605 337.221.0072

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Dental Practice Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care.

Financial responsibility on the part of each patient must be determined before treatment.

As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

Signature: _____ Date: _____

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Notice: X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

Signature: _____ Date: _____

DUHON
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Name: _____ Date of Birth: _____

Demographics

First name: _____

Last name: _____

Sex: _____

Birth date: _____

Email address: _____

Phone number: _____

Address line 1: _____

Address line 2: _____

City: _____

State: _____

Postal code: _____

Signature: _____ Date: _____

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FAMILY DENTISTRY

COVID -19 PATIENT SCREENING

Name: _____ Date of Birth: _____

Do you have a cough?

☐ Yes ☐ No

Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

☐ Yes ☐ No

Have you experienced recent loss of taste or smell?

☐ Yes ☐ No

Have you had any contact with any confirmed COVID-19 positive patients?

☐ Yes ☐ No

Is your age over 60?

☐ Yes ☐ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19?

☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19?

☐ Yes ☐ No

Signature: _____ Date: _____

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Photo Release Form

I hereby authorize Duhon Family Dentistry, or any of their assignees, to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Signature: _____ Date: _____

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