



# NEW ORLEANS DENTAL CENTER MEDICAL HISTORY

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# ( ) \_\_\_\_\_ Work# ( ) \_\_\_\_\_ Cell# ( ) \_\_\_\_\_  
 Email Address (please print) \_\_\_\_\_ Referred by \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? Yes No If yes, please explain \_\_\_\_\_  
 Have you been hospitalized or had a major operation? Yes No If yes, please explain \_\_\_\_\_  
 Have you ever had a serious head or neck injury? Yes No If yes, please explain \_\_\_\_\_  
 Are you taking any medications, pills or drugs? Yes No If yes, please explain \_\_\_\_\_  
 Do you take or have taken Phen-Fen or Redux? Yes No \_\_\_\_\_  
 Are you on a special diet? Yes No \_\_\_\_\_  
 Do you use tobacco? Yes No \_\_\_\_\_  
 Do you use controlled substances? Yes No \_\_\_\_\_  
 Do you need to take antibiotics prior to dental treatment (due to heart condition, prosthetic joint, etc)? Yes No \_\_\_\_\_  
 Have you had eye surgery in the past 8 weeks? Yes No \_\_\_\_\_

Women: Are you Pregnant/Trying to get pregnant? Yes No  
 Taking oral contraceptives? Yes No Nursing? Yes No

Do you like your smile? Yes No Are you nervous? Yes No

Are you allergic to any of the following? No known allergies  
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics  
Sulfa Drugs Sulfite (chemical in local anesthetic) Other If yes, please explain \_\_\_\_\_

Do you have, or have had any of the following?

<input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No Renal Dialysis
<input type="checkbox"/> Yes <input type="checkbox"/> No Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatism
<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Shingles
<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Trouble
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No Spina Bifida
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Intestinal Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Swelling of Limbs
<input type="checkbox"/> Yes <input type="checkbox"/> No Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis
<input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Tumor/Growth
<input type="checkbox"/> Yes <input type="checkbox"/> No Cold Sore/Fever Blister	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers
<input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain \_\_\_\_\_

Person, **NOT LIVING WITH YOU**, to notify in case of emergency:  
 Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Consent:

The undersigned hereby authorizes Dr. Landry, Dr. Maes, and/or their associate dentists, dental hygienists and dental assistants to take x-rays, impressions for study models, photographs, and any other diagnostic aids deemed appropriate by one of the doctors in order to make a thorough diagnosis of the patient's dental needs. **I understand that responsibility for payment for dental services provided by this office for me or for my dependents is mine, due and payable at the time of services rendered, unless prior financial arrangements have been made.** Any fees quoted are valid for 6 months from the date of the treatment plan. **No refunds for professional services rendered will be given.** In the event of default, I (we) promise to pay any legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Insurance Information:

As a **courtesy** to you and your family, our office will send claims, letters, x-rays and any other necessary information to your insurance company for reimbursement of your dental treatment. **You, however, are responsible for monitoring the use of your benefits and for remaining within your maximum covered benefit during each year of coverage.** The deductible and estimated percentage your insurance company does not cover is to be paid in full upon the date of service. According to Louisiana law, **insurance companies must respond within 30 days** of receiving a claim. If we haven't heard from your insurance company within 30 days, we will make two phone calls: one call to your insurance company to find out why they haven't paid and one call to you, to let you know they haven't paid. **After 45 days, any remaining balance from unpaid insurance claims (for example: rejected, denied, or partial payments) will be your personal obligation.** We would like to keep a credit card on file in the event your account is due past 45 days. We will always call you prior to any charges made on your card.

Scheduling Agreement:

You will love how we make appointments at New Orleans Dental Center. We have written an agreement for you to read and sign, to explain how we schedule our appointments. **This agreement will ensure that you will rarely wait to be seen at our office.** You know how when you go to a doctor's office, you sign a clipboard and then you wait indefinitely in the waiting room and nobody even cares that they are late? That's because they have scheduled multiple patients at your appointed time. **We do not double or triple book our rooms,** so when you are scheduled, that time is reserved for you and only you. Therefore, **it is important that you are on time for your appointment.** When we make your appointment, we assume that the appointment is a confirmed appointment, but as a courtesy to you, we will contact you the day before your appointment, either by phone, email or text message, as a reminder. As a result of this process, your appointment cannot be changed once it is made. However, we understand that circumstances arise that can cause patients to change their schedules. **SO, if you have to change your appointment, we will need 24-48 hours notice to do so.** As long as we have this notice, no fees will be charged to you for the schedule change, and we will be able to reschedule your appointment. If we do not have this notice, we may have to see you only on a short-term basis, as well as charge you a fee for the missed appointment. The 24-48 hour notice allows us to be able to see emergency patients on the same day and will also allow you to run your personal schedule more efficiently, as you will know when your appointment begins and when it ends and RARELY HAVE TO WAIT!!! Our patients love this system and we're confident that you will also. **Thank you for your cooperation and understanding.**

**I have read, understand and agree to all of the above:**

Patient's name (please print): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Privacy Practice Acknowledgement:**

I acknowledge that I have received your Notice of Privacy Practices, which contains a complete description of the use and disclosures of my health information.

Patient's name (please print): \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*For Office Use Only\*\*\*\*\*

An effort was made to obtain a signature that the individual received a copy of the Notice of Privacy Practice, but was unable to do as documented below:

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_  
Reason: \_\_\_\_\_