Patient Information

Patient Name: _____ Date:_____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: _____

Email: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply

☐ Allergies _____
_____
☐ Artificial Joints
☐ High Blood Pressure
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Heart Murmur
☐ Please circle one
Hepatitis A- B-C

☐ Depression
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Stroke
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease

☐ HIV
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ Mitro Valve Prolapse
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Pharmacy Used _____ Phone Number _____
List of PRESCRIPTIONS you are on currently taking and what they are used for_____
_____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information Only

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, 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 services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I also understand that it is MY responsibility to either confirm or cancel my appointments with a 24-hour notice. I also understand that if an appointment is broken or failed, that I will be charged a fee and future appointments could require a deposit. Fees for “No show” or “missed appointments” without timely notice will vary.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Financial Responsibility

As a courtesy to you, the patient, this office will file dental claims to your Insurance Company. However, we do not accept responsibility for communication or collections from your Insurance Company.

As the patient, you should verify coverage for your benefits and should be aware of any limitations, waiting periods, or exclusions on your policy. It is your responsibility to communicate with your Insurance Company on a regular basis regarding payment of outstanding claims as needed.

If we do not receive payment from your Insurance Company within 60 days from time of service, you may be required to pay any outstanding balance in full.

Please understand this is not a guarantee of payment by your Insurance Company. All fees are the responsibility of the patient. The Insurance Contract is made between you, the patient, and YOUR Insurance Company. Not our office. The ultimate obligation for payment is with you, the patient.

I have read and understand the above policy:

Patient Signature_____ Date: _____

Welcome!!!!

In order for us to provide the best care possible, we need to know a little about your dental/medical history

Last Name _____
First Name_____

Do you have any concerns about previous dental care or this dental visit?

_____

_____

*Do you smoke? Yes No
*Do you believe your dental health is(circle) : Poor Fair Good Excellent
*Do your gums bleed? (circle) Yes No
*Are you apprehensive about dental treatment? Yes No
*Are your teeth loose? (circle) Yes No
*Do you wear dentures? Yes No If yes, are you happy with them? Yes No
*Would you be interested in implants? Yes No
*Have you ever been told you have gum disease? (circle) Yes No
*Do your gums bleed(circle)? Yes No
*Have you ever been told you have bad breath? (circle) Yes No
*Are your teeth sensitive to? (circle all that apply) Sweets Cold Heat Pressure
*Do you floss regularly? Yes No
*Are you happy with your smile? (circle) Yes No
If no, please explain:

_____

_____

_____

What would you change about the present condition of your mouth?

_____

_____

_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature_____
Date _____

Dr. Deniger & Silvestri
2300 East Gause Blvd.
Slidell, La 70461
Tel: 985-641-7200
Fax: 985-641-7047

Important Insurance Information

Although dental insurance benefits are requested for resin restoration (composite filling), dental contracts provide an allowance for an amalgam restoration (silver filling). Therefore, an allowance will be made for a comparable amalgam restoration on a posterior tooth (molar.) In this situation our office will bill the insurance company and any difference between our charge and the insurance allowance is the patient's responsibility.

I, _____ do understand that the difference not paid by my insurance company is my responsibility.

Patient's signature_____Date_____