WELCOME TO SMILES BY SOILEAU

PERSONAL info

Name _____ Social Security #_____ Birth Date_____

Employer_____ Name of Spouse_____

Home Address_____

City/ State/ Zip/_____

Who may we thank for referring you to our office? _____

Newspaper Ad _____ Newspaper Insert _____ Valpak____ TV Commercial_____ Online Deals_____

CONTACT info

Cell #_____ Home #_____ Work #_____

Email_____

Emergency Contact: Name_____ Number_____

INSURANCE coverage

Insurance Company Name: _____

Policy Number: _____

Name of covered employee: _____ Social Security of cover employee:_____

AUTHORIZATION & release

I authorize Dr. Soileau or his employees to release any information concerning my dental treatment or my child's dental treatment to third party payers and/or other medical/dental offices.

_____

Signature of patient or legal guardian

Medical History- Please complete all sections Name_____ Date_____

Medications: (Including "over the counter" i.e. aspirin, vitamins) **( ) NONE**

_____ _____
_____ _____
_____ _____

Allergies: ( ) Penicillin ( ) Codeine ( ) Latex ( ) Other _____ **( ) NONE**

Heart Problems: ( ) NONE

( ) High Blood Pressure (What is your usual Blood Pressure? ____/____)
( ) Heart Murmur
( ) Stroke
( ) Heart Attack
( ) Heart Valve
( ) Pace Maker
( ) Rheumatic Fever
( ) Angina

Do you need to take antibiotics before a dental appointment? Yes ( ) No ( )

Bleeding:

Do you bleed easy? Yes ( ) No ( )
Do you have Hepatitis? Yes ( ) No ( )
Are you on blood thinners? Yes ( ) No ( )
If so, which one? A ( ) B( ) C( ) D( ) Jaundice( )

Diabetes: Yes ( ) No ( ) If yes, is your diabetes under control? Yes ( ) No ( )

Breathing Problems

( ) Allergies
( ) Asthma
( ) Sinus Problems
( ) Bronchitis
Snoring ( ) *Ask your spouse!*
( ) NONE

Do you need help sleeping? Yes ( ) No ( ) If so, what do you do? _____
Were your tonsils removed? Yes ( ) No ( ) Do you wake up tired? Yes ( ) No ( )
Do you use a CPAP for sleeping? Yes ( ) No ( ) How often do you wake up at night? _____
Do you have sleep apnea? Yes ( ) No ( ) When were you diagnosed? _____
*Would you like information on an FDA approved treatment for sleep apnea? Yes ( ) No ( ) *

FEMALES:

Are you pregnant or breast feeding? Yes ( ) No ( ) If so, when is your due date? _____

Cancer: Do you (or have you ever had) cancer? Yes ( ) No ( )
When diagnosed? What kind? _____
How are you or were you being treated? Surgery ( ) Chemo ( ) Radiation ( )
** Some cancer treatments alter the oral environment; Pre-cancer symptoms may first appear in oral tissue **

General Questions:

Do you smoke? Yes ( ) No ( ) How often/ how many packs per day? _____
Would you be interested in Sedation for particular procedures? Yes ( ) No ( )
Any JOINT Replacements? Yes ( ) No ( ) Surgery Date:_____ Surgeon: _____

Nerves/Muscles/Bones:

Can you recline back comfortably in the dental chair? Yes ( ) No ( )
Do you have a Neuromuscular Disorder? Yes ( ) No ( ) If so, what is it? _____

Immune System:

Lupus ( ) Organ transplant ( ) HIV ( ) AIDS ( ) ARC ( ) **NONE ( )**

Primary Physician: _____ **Location:** _____

Specialist: _____ **Location:** _____

Consent for Treatment

By state law we are required to make an attempt to inform patients of possible complications, even though rare, which could result from anesthesia, local and/or sedation.

- Allergic reactions which could require hospitalization.
- Cardiac arrest, which could result in brain damage or even death.

It must be understood that these complications are extremely rare and every possible precaution will be taken to prevent their occurrence as well as to treat them successfully should they occur.

The most common, even though rare, complications resulting from tooth extractions, periodontal therapy, cyst removal, biopsies, filling, root canal therapy, crowns, veneers, bridges, etc, are:

- Bleeding heavy enough to stop therapy.
- Injury to adjacent teeth and fillings.
- Post-operative infection requiring additional treatment
- Possibility of a small piece of root being left in the jaw when its removal would require extensive surgery.
- Fracture or breakage of the jaw.
- Post-operative discomfort and swelling which may necessitate several days of home recuperation.
- Stretching of the corners of the mouth resulting in cracking and bruising.
- Nerve injury, sensory and/or motor, adjacent or on the side of the surgical site, especially underlying the teeth resulting in numbness of the palate, lips, tongue, chin, face, or other anatomical structures in the head and neck.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- Tooth sensitivity, which may require additional treatment.
- Tooth mobility.
- Recession of the gingival (gums).

_____ _____

Patient or guardian's signature Date

Member of : Acadiana Dental Distric Assoc., Louisiana Dental Association
Academy General Dentistry, American Dental Association
American Academy Cosmetic Dentistry, Fellow Academy Comprehensive Esthet

1144 Coolidge Blvd
Suite D
Lafayette, LA
337/234.3551

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Louisiana Dental Assoc.
Academy General Dentistry
American Dental Assoc.

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your Notice of Privacy Practices Acknowledgement containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the contained address to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Signature _____

Photographic Release

I _____, hereby authorize Dr. Tony Soileau to take photographs, slides, and/or video of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television, etc) and professional publications (dental magazines and journals). I do not expect compensation, financial or otherwise, for the use of the photographs, slides, or videos.

Signature_____

Patient Name: _____

Relationship to patient: (if a minor)_____

Date: _____

Financial Agreement

I agree to pay Dr. Tony Soileau FOR PROFESSIONAL SERVICES RENDERED, OR TO BE RENDERED, at the time the service is performed unless other arrangements have been made in advance. I understand that any balance past due over 30 days from the first billing date will be subject to an **interest charge of 1.5% per month** (18% annual rate) if I elect not to pay within 30 days.

I also understand that insurance benefits assigned to Dr. Tony Soileau must be paid within 60 days from the date of insurance billing. If insurance has not paid within 60 days I agree to pay Dr. Tony Soileau the full balance. Any payment received by Dr. Tony Soileau after my balance is paid will be refunded to me. I understand that Dr. Tony Soileau's office cannot be responsible for collecting my insurance claim or for negotiating a settlement on a disputed claim. I understand I am ultimately responsible for this account no matter what my insurance may or may not pay.

I agree to give at least **24 hours notice** if I need to change my appointment. If Dr Soileau's office isn't notified within at least 24 hours orI do not show up, I will be subject to a **$95 fee**.

ALL patients are **REQUIRED** to have an appointment. Credit card information is required for appointment reservation. I understand a fee will be charged to my card if I do not comply with the 24 hour notice policy for cancelations, no-shows, or reschedules. Fees will vary according appointment production. **We do not accept walk-ins**. Any arrivals **15 minutes** past scheduled appointment time will have to be rescheduled.

I understand that fee estimates quoted are based on all appointments being kept. The fee will be higher if there are frequent short notice cancellations or appointment changes. Fees quoted will remain valid for 90 days. If I decide to stop completion of paid in full treatment, refunds will be provided minus any office expenses, including missed or no show appointments charges. Any appointment involving Dr Soileau's time, which is normally considered goodwill and not charged, will be charged a fee of $375/hour. Fees will be deducted from total paid and the balance will be refunded.

I understand that if it is necessary for Dr. Tony Soileau to retain the services of an attorney to collect my unpaid balance I will be responsible for all court cost, attorney fees, and any other collection fees which may be incurred as a result of my account being turned over for collections as allowed by the State of Louisiana.

I agree to pay a fee of $25.00 for a check retuned N.S.F.

I have read and understand the above agreement.

1144 Coolidge Blvd
Suite D
Lafayette, LA
337/234.3551

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Louisiana Dental Assoc.
Academy General Dentistry
American Dental Assoc.
American Academy Cosmetic Dentistry
Fellow Academy Comprehensive Esthetics

Signature of patient or guardian _____ **Date** _____

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Academy General Dentistry, American Dental Association
American Academy Cosmetic Dentistry, Fellow Academy Comprehensive Esthetics

Name: _____	Date_____ Age _____	Height _____ ft. _____in Weight _____ pounds
Sleep Apnea Yes ❑ No ❑	Restless Leg Synd Yes ❑ No ❑	Hypertension Yes ❑ No ❑
Nasal Oxygen Yes ❑ No ❑	Morning Headaches Yes ❑ No ❑	Heart Disease Yes ❑ No ❑
Insomnia Yes ❑ No ❑	Sleep Medication Yes ❑ No ❑	Lung Disease Yes ❑ No ❑
Narcolepsy Yes ❑ No ❑	Pain Medication Yes ❑ No ❑	Diabetes Yes ❑ No ❑

Use the following scale to choose the most appropriate number for each situation:

0 Would never doze **1 Light chance** **2 Moderate chance** **3 High chance**

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in public place (meeting; theater)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when permitted	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopping for a few minutes in traffic	0	1	2	3

RATE THE FOLLOWING SITUATIONS IN FREQUENCY PER WEEK

On average in the past month, how often have you snored or been told you snored?

NEVER ❑ **RARELY** ❑ **SOMETIMES** ❑ **FREQUENTLY** ❑ **ALMOST ALWAYS** ❑

Do you wake up choking or gasping for air?

NEVER ❑ **RARELY** ❑ **SOMETIMES** ❑ **FREQUENTLY** ❑ **ALMOST ALWAYS** ❑

Have you been told that you stop breathing in your sleep or wake up gasping?

NEVER ❑ **RARELY** ❑ **SOMETIMES** ❑ **FREQUENTLY** ❑ **ALMOST ALWAYS** ❑

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

NEVER ❑ **RARELY** ❑ **SOMETIMES** ❑ **FREQUENTLY** ❑ **ALMOST ALWAYS** ❑