

FAMILY DENTISTRY at the LAKES

Wilton Guillory Jr., D.D.S.

Courtney Richter, D.D.S.

David Carlton III, D.D.S.

Aaron Mangum, D.D.S.

5422 Provine Place
Phone 318-445-4870

Alexandria, LA 71303
Fax 318-473-8289

PATIENT INFORMATION

Please print

First Name	M.I.	Last Name	Nickname	Age
Address		City/State		Zip
Home Phone ()	Date of Birth / /	Male ___ Female ___	Student Yes / No	
Social Security Number		Employer Address		
Patient's Employer		City/State/Zip		
Work Number ()	Cell Number ()		Other ()	
Referred by	Emergency Contact & Number			
Family Physician	Physician Number			
Email	Preference for Confirming Appts? Email/ Phone			

PERSON RESPONSIBLE FOR PAYMENT

Name	Relation to Patient
Address	Employer
City/State/Zip	Address
Home ()	City/State/Zip
Cell ()	Work Number ()
Social Security Number	Date of Birth
Email	Driver's Lic. Number

INSURANCE

Name	Employer
Social Security Number	Date of Birth
Address(if different from patient)	City/State/Zip

PATIENT MEDICAL HISTORY

	YES	NO	?
1. Are you taking any medication or drugs? Please list:			
2. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications? List:			
3. Are you under the care of a physician for a current problem? If yes, explain			
4. Have you been hospitalized within the past 5 years? Please specify.			
5. Is there any other condition concerning your health about which the doctor should be told?			
6. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
7. Have you ever tested positively for Hepatitis, HIV infection or AIDS? If so, state date diagnosed:			

8. Are you required to take antibiotics prior to dental treatment? Why?			
9. Women only: are you pregnant, nursing or on birth control pills?			

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

- High blood pressure
- Heart murmur or prolapsed valve
- Joint replacement (hip, knee, etc.)
- Rheumatic fever or rheumatic heart disease
- Congenital heart disease
- Cardiovascular disease (heart attack, stroke, bypass)
- Prosthetic heart valve
- Blood disorder (e.g. anemia)
- Venereal disease
- Temporomandibular Joint problems (TMJ)
- Allergy to latex
- Low blood pressure
- Contagious disease/ infection (e.g. staph.)
- Swollen ankles, arthritis or joint disease
- Cardiac pacemaker
- Heart surgery
- Infectious mononucleosis
- Tuberculosis
- Emphysema
- X-Ray treatment or chemotherapy
- Acid reflux regularly
- History of alcohol/ drug abuse

- Sinus trouble
- Thyroid problems
- Diabetes/ Low Blood Sugar
- Stomach ulcers, colitis
- Hepatitis, jaundice, liver disease
- Psychiatric treatment
- Fainting spells or seizures
- Epilepsy
- Cancer
- Asthma
- Loss of major organs
- Dialysis/ Kidney problem
- Irregular heart beat
- Chest pain, angina
- Bronchitis, chronic cough
- Hay fever
- Problems with the immune system
- Difficult breathing or other lung trouble
- Chronic fatigue or night sweats
- Organ transplantation
- Bruise/ Bleed easily
- None of the Above**

Help our doctors get to know you better:

	YES	NO	?
1. Has it been more than 1 year since your last dental visit? If so, how long?			
2. Do you have anxiety or experience fear in the dental chair?			
3. Are you happy with your smile? If not, why?			
4. Do you like the color of your teeth?			

5. Are you happy with the shape/ position of your teeth?			
6. Do you have frequent headaches?			
7. Does your jaw pop or click?			
8. Do you clench or grind your teeth?			
9. Are you here today for a specific dental need? If so, what?			

Please Sign After Reading:

Charges for dental services are due and payable at time of the service. Payment may be made with cash, check, Visa, MasterCard, or Debit cards.

I understand that I (or the guarantor listed) am ultimately responsible for any delinquent charges in association with collector and/or attorney's fees.

Patients with Insurance: As a courtesy to our patients, this office will process your dental insurance claims for your convenience.

I understand that the "Estimated Patient's Portion" that may be quoted to me is *only an estimate*. I authorize payment of the dental benefits payable to the doctor(s). I understand that I am fully responsible for all charges made at this office excluding any insurance payments and am aware that if my insurance has not paid the doctor(s) within six (6) weeks from the date of service, I am responsible for paying the balance immediately.

Consent: It is necessary for us to have the consent of our patients or a parent/ legal guardian of minors prior to rendering dental services.

My signature below therefore authorizes the doctor to perform any and all forms of dental treatment, medication, and/or therapy that may be indicated. I understand the dental treatment or course of dental treatment has a risk of death, brain damage, quadriplegia,

paraplegia, the loss of function or loss of an organ or limb, or disfiguring scars, and that I may ask questions concerning such dental treatment or course of dental treatment.

It is also necessary for us to have the consent of our patients or a parent/ legal guardian of minors to email dental x-rays and/or dental photographs to other dental professionals such as specialists or laboratory technicians via a non-encrypted web source.

My signature below therefore gives the doctor and/or qualified staff of *Family Dentistry at the Lakes* permission to email other dental professionals my dental x-rays or pictures as needed for my individual treatment needs.

HIPPA Policy: As health care providers, we are legally required to protect the privacy of your health information and to provide you with this notice about our legal duties and privacy practices.

Please read the HIPPA Policy Form before signing below.

I have read the HIPPA Policies and understand all information provided.

Patient Signature (Parent signature if patient is under 18 years of age).

Date