

Bluebonnet Dental Care

Medical / Dental History

Name _____ Age _____ Date _____

Check any of the following that you have or have had in your lifetime:

<input type="checkbox"/> Epilepsy/Seizures / Date _____	<input type="checkbox"/> Psychiatric Disorder	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Recurrent Bronchitis	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Heart surgery / Date _____	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Attack / Date _____	<input type="checkbox"/> Hepatitis (type A,B,C)	<input type="checkbox"/> Anemia/Hemophilia
<input type="checkbox"/> Stroke / Date _____	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chest Pains/Angina	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Asthma
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Cancer
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Other _____	

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

Are you ALLERGIC to: _____ Penicillin? _____ Aspirin? _____ Codeine? _____ Other? _____

Do you smoke? _____ Packs per day? _____

Do you use alcoholic beverages? _____ Drinks per week? _____

LADIES ONLY: Are you pregnant? _____ If so, what month? _____

When was your last dental visit? _____

Why did you leave your last dentist? _____

What treatment would you like to have completed? _____

Have you ever had any of the following dental treatment:

<input type="checkbox"/> Extraction/Date _____	<input type="checkbox"/> Crowns/Bridges	<input type="checkbox"/> Cosmetic Whitening
<input type="checkbox"/> Root Canal/Endodontics	<input type="checkbox"/> Partial Dentures	<input type="checkbox"/> Veneers
<input type="checkbox"/> Fillings	<input type="checkbox"/> Complete Dentures	<input type="checkbox"/> Orthodontics
<input type="checkbox"/> Gum/Periodontal Surgery	<input type="checkbox"/> Implants (dental)	<input type="checkbox"/> Other _____

For any existing crowns, bridges, partials, or dentures. How old? _____

I brush _____ times a day.

I floss _____ times a day.

How often do you visit the dentist? _____

WELCOME TO OUR PRACTICE!

Patient Information

Patient's Name (____) - _____
Home Phone

Address City State Zip (____) - _____
Cell Phone

____/____/____
Date of Birth Social Security Number E-mail address

Patient's Employer Employment Address (____) - _____
Work Phone

Guarantor / Insurance Information

Dental Insurance Company Phone Group Number

Guarantor / Policy Holder's Name (____) - _____
Phone

____/____/____
Date of Birth Social Security # / Subscriber ID # Relationship to patient

Policy Holder's Employer

Emergency Contact Information

Name (____) - _____ (____) - _____
Home Phone Cell Phone Relationship to Patient

How Did You Hear About Our Office?

(please circle one)

*Yellow Pages *Sunshine Pages *Radio *TV *Internet * Mailer *Other _____

Your Children's Names and Ages

Hobbies and Interests

CONSENT

For Dental Treatment and

Acknowledgement of Receipt of Information

State law requires us to obtain your consent for the contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct **Dr. Andre' Bruni** with associates, assistants, hygienists, and specialists of their choice to perform upon _____ the following dental procedures:

Photographs, radiographs, study models, extraction and other surgical procedures, biopsies, periodontal cleaning and/or surgery, fillings, root canals, partials and/or complete dentures, crowns, bridges, bleaching and tooth lightening procedures, porcelain and resin veneers, lumineers, and splints including any necessary or advisable anesthesia.

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:

Alternatives to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

RISK ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetic are:

Swelling and bruising which may necessitate staying home for a few days.

Bleeding sometimes prolonged enough to necessitate additional services to cause it to cease.

Instrument breakage

Retained instrument fragment(s)

Breakage of roots

Retained root fragments

Parasthesia – permanent or temporary numbness of the cheeks, gums, teeth, lips, tongue, chin, and face

Loss of taste

Loss/damage to adjacent teeth and bone

Fracture of the jaw

Sinus involvement

Change in the bite

TMJ Dysfunction or worsening of TMJ condition

Trismus (jaw pain or difficulty opening the mouth)
Swallowing/aspiration of objects
Infection/dry socket
Pain
Drug/allergic reaction
Stretching of the mouth which may cause bruising or result in cracking
Failure of the treatment to accomplish its purpose
Further surgery or treatment

USE OF ILLICIT DRUGS:

The use of illicit or street drugs can adversely affect treatment, including anesthesia and sedation, possibly resulting in death. Please notify the doctor if you have used any drugs within the last 24 hours.

State law also requires that I specifically advise you that, although rarely occurring, the dental treatment of anesthetic may result in death, brain damage, quadriplegia, paraplegia, loss of organ(s), loss of function of an organ(s), loss of function of face, arm(s), or leg(s), and disfiguring scars.

Photographs:

I hereby specifically authorize the above doctors and staff to take, develop and use photographs at all phases of my treatment for educational, demonstrative and/or promotional purposes specifically including use in lectures and publications and I do hereby forever waive any claim to royalties or other monies or other sources of reimbursement that are received from their use.

ACKNOWLEDGEMENT

I acknowledge that I have read and I understand the information on both pages of this consent form (or that it has been read to me). I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about treatment. All of the questions about the treatment have been answered in a satisfactory manner. I understand that the success of this treatment and the avoidance of treatment complications depends to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, and my keeping appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s), where further treatment may be discussed, or administered, which is not currently anticipated. I hereby authorize **Dr. Andre' Bruni** and/or associates, hygienists, specialists or assistants of their choice to perform diagnostic, surgical or dental treatments. This Consent Form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive further disclosures or information.

Date _____
Signature of Patient _____
Signature of Parent/Guardian _____
Dentist _____ Witness _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- *Obtaining payment from third party payers (e.g. my insurance company);
- *The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions, However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Bluebonnet Dental Care

*Dr. Andre Bruuni
4451 Bluebonnet Blvd., Ste. A
Baton Rouge, LA 70809*

ACKNOWLEDGEMENT

I hereby certify that the medical and dental history provided is correct to the best of my knowledge and give my consent for the doctors and staff at Bluebonnet Dental Care to treat my dental needs based on this information.

FINANCIAL ARRANGEMENT AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

In order to be impartial to everyone, WE REQUIRE PAYMENT AT THE TIME OF THE TREATMENT. We ask that you read and sign this statement prior to any treatment. YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF THE TREATMENT. We accept cash, checks, Visa, MasterCard, Discover Card, and American Express. For extensive treatment plans, we offer extended payment plans with CareCredit at either little or no interest with prior credit approval.

MISSED APPOINTMENTS

In order to be fair to all our patients, we ask that you notify our office at least 72 hours in advance if you cannot keep your scheduled appointment. Our policy for any missed appointments is a charge of a normal office visit.

REGARDING INSURANCE

We will gladly file all dental claims for a given treatment but we are not party to any insurance programs or contracts. The balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.

I authorize Bluebonnet Dental Care to release any dental information necessary to process dental insurance claims. I also request and authorize payments of any benefits, applicable to services rendered, to Bluebonnet Dental Care.

FINANCE CHARGES

Be aware that any unpaid balance after 60 days is charged a yearly finance charge of 18% and that this finance charge is equal to 1.5% of the outstanding balance per month. If the account reaches collections status an no effort is made to pay it off, the account will be assigned to a collection attorney of agency. If the doctor must take additional steps to collect the account, all costs of collection including court costs and attorney's fees incurred by the doctor will be charged to the patient.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Date _____ Signature _____

Phone _____ Approved By _____

