Family Dentistry
Registration and Health History
Patient Information

Patient's Name: *Last* _____ *First*_____ *MI*_____
Address: *Street* _____*Apt #*_____*City* _____*State*_____ *Zip*_____
Phone: *Daytime:* _____-_____-_____ *Alternate:* _____-_____-_____ *Work:* ____-_____-_____
Date of Birth: _____/_____/_____ **Social Security #:** _____ **Sex:** *M F*
Occupation: _____ **Marital Status**: *Single Married Other*
Email Address for confirmation purposes only: _____

Responsible Party *(parent or guardian if patient is a minor)*

Name: *Last* _____ *First*_____ *MI*_____
Address: *Street* _____*Apt #*_____*City* _____*State*_____ *Zip*_____
Phone: *Daytime:* ____-_____-_____ *Alternate:* _____-_____-_____ *Work:* _____-_____-_____

Emergency Contact

Name: *Last* _____*First* _____*Phone #:*____-_____-_____ *Relationship:*_____

Dental History

Reason for today's visit: _____ Former Dentist: _____
When was your last dental exam? _____ Were X-Rays taken? _____
How often do you brush? _____How often do you floss? _____
Are you happy with the appearance of your teeth? **Y N**
Are you interested in cosmetic dentistry? **Y N**
Are you nervous about Dental Treatment? **Y N**

Please circle the following conditions that apply to you:

Bad Breath	Grinding Teeth	Sensitivity to Hot/ Cold
Bleeding Gums	Loose Teeth	Sensitivity to Sweet
Broken Fillings	Clicking/ Popping Jaw	Sensitivity when Biting
Food collections in teeth	Periodontal Treatment	Sores or Growth in Mouth

Medical History

Physician: _____ Date of Last Visit: _____
Please list any Prescribed or Over the Counter Medicines that you are taking: _____
_____
Please list any Drug or Chemical Allergies: _____

Please circle the following conditions that apply to you:

ADD/ADHD	Circulatory Problems	Hemophilia	Scarlet Fever
AIDS	Cortisone Treatments	Hepatitis	Shortness of Breath
Alzheimer	Cough, Persistent	High Blood Pressure	Sickle Cell Anemia
Anemia	Cough up Blood	HIV	Skin Rash
Arthritis	Diabetes	Jaw Pain	Swelling: Ankle/ Feet
Artificial Heart Valves	Down Syndrome	Kidney Disease	Thyroid Problems
Artificial Joints	Epilepsy	Liver Disease	Tobacco Habit
Asthma	Fainting	Mitral Valve Prolapse	Stroke
Autism	Fever Blisters	Nervous Disorder	Tonsilitis
Back Problems	Glaucoma	Pacemaker	Tuberculosis
Blood Disease	Hay Fever	Psychiatric Care	Ulcer
Cancer	Headaches	Radiation Treatment	Venereal Disease
Chemical Dependency	Heart Murmur	Respiratory Disease	Others Not Listed: _____
Chemotherapy	Heart Problems	Rheumatic Fever	_____

Females: Are you pregnant? **Y N** Are you nursing? **Y N** Are you taking Birth Control Pills? **Y N**

Authorization

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND QUESTIONS NOT ANSWERED OR INCORRECTLY ANSWERED CAN BE HAZARDOUS TO MY HEALTH.

Signature of Responsible Party: _____ Date: _____

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

Our Policy Regarding Appointments and Payments

Our staff goes to great lengths to provide the quality of care that we feel each of our patients deserve. When we schedule your appointments, we follow carefully planned protocols to maintain that goal. As a courtesy, our staff will call at least 48 hours in advance to confirm each of your appointments. If we are not able to reach you or you receive a voicemail, please call our office to verbally confirm your appointment time. This will help us be better prepared for your arrival. **Please understand that we may not be able to hold your appointment time if we are unable to confirm your appointment.**

We do respect our patient's schedules and we asked that you would also have respect for our schedule and the schedule of others. Late arrivals cause us to run late for other patients. Please understand that arriving after your appointment time may result in the rescheduling of your appointment. We do understand unexpected events and emergencies can happen. Please let the office know was soon as possible that you can not make your appointment time. If it does not interfere with other patient's schedule we will be happy to accommodate you.

We do ask for 48 hours notice to reschedule or cancel an appointment. Multiple rescheduled or canceled appointments may result in additional charges that would need to be paid prior to scheduling future appointments.

PAYMENT IS DUE AT TIME OF SERVICE.

****************Attention Insurance patients****************

Please understand that we file dental insurance as a courtesy to our patients. Any unpaid balances are the responsibility of the patient. Any balances past 30 days is assessed a $15 late fee. Any balances past 60 days will be sent to Transworld Collection Agency.

Patient Signature_____
Date_____

NOTICE OF PRIVACY PRACTICE ACKOWLEDGEMENT

Diem Duy Do, D.D.S.
5220 Lapalco Blvd.
Marrero, LA 70072

I acknowledge that I have been informed or your notice of Privacy Practice, which contains complete description of the use and disclosure of my health information. I understand that the notice will be provided to me at my request.

Patient's Name (please print):_____
Patient's Signature: _____ Date: _____

If patient is a minor and/ or personal representative of the patient signs on behalf of the patient, please complete the following:

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 so as documented below.

Date: _____ Initials:_____
Patient's Name: _____
Reason: _____
_____