# Dr. John C. Moreau and Associates

3820 Masonic Dr. Service Road
Alexandria LA 71301
318-442-9555
Alexandriadentalpractice.com


Date____/____/____

Patient's Last Name_____First_____MI_____

Home Phone (  )_____Work (  )_____Cell Phone (  )_____

Home Address_____City_____State_____Zip_____

Mailing address_____City_____State_____Zip_____

Social Security #_____-_____-_____ Sex_____ Marital Status_____

DOB_____/_____/_____ Age_____ Spouse's Name_____

Email Address_____

## Responsible Party if different from Patient

Father/Guardian: Last Name_____First Name_____

Father/Guardian: Address_____

Email address_____

Home/cell phone _____Work phone_____

Mother/Guardian: Last Name_____First Name_____

Mother/Guardian: Address_____

Email address_____

Home/cell phone _____Work phone_____

## In case of an Emergency, Contact (please specify someone who does not live in you household.)

Name _____Relationship to patient_____

Address_____City_____State_____Zip_____

Home/cell phone (_____)_____Work phone (_____)_____

## Who may we thank for referring you?_____

(Patient, Doctor, Website, Sign, Walk-in, Etc.)

## Please fill this form out COMPLETELY.

# HEALTH HISTORY

**Name** _____ **Date** _____

**Date of last health care exam** _____ **What was this exam for?** _____

**Have you been hospitalized in the last 5 years? (Please circle) NO YES**

**If yes, reason** _____

**Are you currently receiving care? NO YES If yes, nature of care:** _____

**Please list all the names and phone numbers of the physicians who are currently providing you care:**

1. _____
2. _____
3. _____
4. _____

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please not that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

| | | | | | |
|---|---|---|---|---|---|
| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
| Arthritis, Rheumatism or other inflammatory disease? | No | Yes | Joint Replacement? When placed? | No | Yes |
| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | Psychosis | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Previous Biopsies | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Rheumatic Fever | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS or ARC | No | Yes |
| Congenital Heart Disease | No | Yes | Venereal Disease | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Other Conditions | No | Yes |
| Heart Stent? When Placed? | No | Yes | Recurrent Illnesses | No | Yes |

**Are you taking any of these medications?**

| | | | | | |
|---|---|---|---|---|---|
| Pre Med needed for artificial bone, heart condition, etc? | No | Yes | Tagamet (cimetidine) or Prilosec (omeprazole) ? | No | Yes |
| Antacids? | No | Yes | Cardizem (diltiazem) or Calan, Isoptin (Verapamil)? | No | Yes |
| Dilantin or Tegretol | No | Yes | Serzone (Nefazodone) | No | Yes |
| Barbiturates (any) | No | Yes | Diflucan (fluconazole) or Sporonox (Itraconazole) | No | Yes |
| St. John's Wort or Kava-Kava? | No | Yes | Biaxin (Clarithromycin) | No | Yes |
| Have you been treated with Biphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? If so when did the treatment Begin? End? | | | | No | Yes |
| Have you ever taken any prescription drugs such as fen-phen for weight loss? | | | | No | Yes |
| Do you consume grapefruit juice, grapefruits or grapefruit extract? | | | | No | Yes |

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? (please circle) NO YES
If no, are you planning a pregnancy in the near future? NO YES
Are you a nursing mother? NO YES
Are you taking birth control pills? NO YES

Abnormal Blood Pressure? (please circle) NO YES
Have you ever received a diagnosis of "high blood pressure"? NO YES
What is your normal blood pressure? _____S / _____D Today? _____/_____

Are you Allergic or have you had a reaction to:

a. Local anesthetics..... NO YES
b. Penicillin or other antibiotics (please specify)..... NO YES
c. Aspirin, Ibuprofen or Tylenol (please specify)..... NO YES
d. Codeine, Valium or other sedatives (please specify)..... NO YES
e. Latex or Metals..... NO YES
f. Other (please specify) _____

Tobacco, Alcohol or drugs
Do you use tobacco? (circle one) NO YES, If yes circle type (circle one): smoke chew
How much per day? _____ For how long?_____ Do you want to quit using tobacco? NO YES (circle one)
Do you consume alcohol? (circle one) NO YES, If yes approximately how many alcoholic beverages per week? _____
Do you use any mood altering drugs other than those previously listed? (circle one) NO YES

Weight and Diet considerations:

| Weight | Meals Per Day | Dietary Restrictions | Food Allergies |
|---|---|---|---|
| | | | |

Sugar in you diet (circle one) *none* *slight* *moderate* *high*

**DOCTOR'S USE ONLY:**
Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental Management Considerations:

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you will have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

Patient (Print Name) _____ Patient Signature _____ Date _____

Doctor (Print Name) _____ Doctor Signature _____ Date _____

## Dr. John Moreau and Associates

### ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE

DATE: _____

PATIENT NAME (PLEASE PRINT): _____

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE: _____

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## Patient Cancellation & Missed Appointment Policy

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

If you need to reschedule or cancel and appointment, we require a minimum of 48 hours notice. Please call the office at (318) 442-9555.

"Missed Appointments" or last minute cancellations also leave empty appointment times, as well as other patients waiting to receive dental care. For that reason, patients that do not notify the office of a cancellation and are not present for their scheduled appointment will be charged a cancellation fee as follows:

Less than 48 hours notice and Missed Appointment:
New patient: $50.00
Existing Patient: $35.00

We realize that on rare occasion, emergencies may arise and we will address these situations with you at that time. Also, if there are any changes in phone numbers, please contact our office with these changes so we may confirm your future appointments. If we can't confirm your appointment the day prior to the scheduled appointment, you risk losing the appointment.

We thank you for working with us to ensure services are provided to you in the best possible way.

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### ACKNOWLEDGEMENT OF CANCELLATION & NO SHOW POLICY

Your signature on this document indicates your understanding and acceptance of our policy regarding cancellation and/or missed appointments. If you should have any questions regarding this policy, Dr. Moreau's office will be happy to discuss them with you.

Patient Name: _____

Signature: _____

Date: _____

# From the Office

## Of

## Dr. John Moreau & Associates

As a service to our patients, we are glad to accept assignment directly from your insurance company. Please remember however, that the financial obligation for dental treatment is between you and this office, and is not between us and the insurance company. We will gladly calculate your co-payment after verifying your benefits with the insurance company. Co-payments and any deductibles are due and payable upon date of service. Should financial arrangements be needed, we will be happy to discuss options with you.

Please read and sign this statement in agreement of our policy of accepting assignment from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim. We are glad to answer any questions you may have.

I hereby authorize payment directly to Dr. John C. Moreau, D.D.S, or and Associates of the group insurance benefits otherwise payable to me.

I authorize release of any information relating to my treatment to the group insurance carrier.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 45 days, I will be responsible for the full amount owed to Dr. John C. Moreau, and Associates.

I understand that after the insurance company pays, there could still be a remaining balance, which is payable in full, by me, upon receipt of statement.

*We thank you for choosing us to provide your dental care!* ☺

_____ _____

*Signature of Responsible Party* *Date*

# INSURANCE INFO

## Primary Dental Insurance

Co. Name: _____

Address: _____

_____

City State Zip

Phone #: (___)_____

Insured's SSN/ID: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

## Secondary Dental Insurance

Co. Name: _____

Address: _____

_____

City State Zip

Phone #: (___)_____

Insured's SSN/ID: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____