10343 Siegen Lane, Bldg. #1-A
Baton Rouge, LA 70810
225.757.8450
Fax 225.757.8454

719 E Airport Ave, Ste A
Baton Rouge, LA 70806
225.924.3369
Fax 225.924.3387

Welcome

Patient Information

Patient Name_____ □ Male □ Female
Last First MI
Address_____
Street City State Zip
Home Phone _____ Work Phone_____ Cell _____
Birth Date ___/___/_____ Social Security #_____
Marital Status □ Single □ Married □ Separated □ Widowed □ Divorced
□ Significant Other
Email Address_____
Whom may we thank for referring you? _____
Employer _____Occupation_____

Responsible Party Information

Name _____ SS# _____
Address if different than above_____
Home Phone _____Work Phone_____ Cell _____

Dental Insurance

Insured's Name _____SS#_____
Dental Insurance Co _____ Phone #_____
Group # _____ Group Name _____
Insured's Employer _____ DOB Insured_____

Emergency Contact

In Case of Emergency whom should we contact?
Name _____ Relationship_____ Ph#_____
To the best of my knowledge all the preceding answers are true and correct. I will inform your office of any changes at the next appointment.

_____ Date _____
Signature (18 & under – Parent or Guardian)

Medical Questionnaire

Name of Physician _____

Date of last physical examination_____ Purpose_____

What is your estimate of your general health? □ Poor □ Fair □ Good

Have you ever had the following : YES NO

1. Hospitalization for illness or injury.... □ □

2. Allergic reaction to:
   - □ aspirin
   - □ penicillin
   - □ erythromycin
   - □ codeine
   - □ local anesthetic
   - □ fluoride
   - □ metals (gold, stainless steel)
   - □ any other medications _____

	Yes	No		Yes	No
3. Heart problems	□	□	30. Epilepsy, seizures	□	□
4. Heart murmur	□	□	31. Viral Infections,cold sores	□	□
5. Rheumatic fever	□	□	32. Lumps, swelling in mouth	□	□
6. Scarlet fever	□	□	33. Hives, skin rash, hay fever	□	□
7. High blood pressure	□	□	34. Venereal disease	□	□
8. Low blood pressure	□	□	35. Hepatitis (type_____)	□	□
9. A stroke	□	□	36. HIV/AIDS	□	□
10. Artificial prosthesis (valves, joints)	□	□	37. Tumor, abnormal growth	□	□
11. Anemia or other blood disorder	□	□	38. Radiation therapy	□	□
12. Prolonged bleeding due to a cut	□	□	39. Chemotherapy	□	□
13. Emphysema	□	□	40. Emotional problems	□	□
14. Tuberculosis	□	□	41. Psychiatric treatment	□	□
15. Asthma	□	□	42. Antidepressant medication	□	□
16. Sinus problems	□	□	43. Alcohol / drug dependency	□	□
17. Kidney disease	□	□	**Are You**		
18. Liver disease	□	□	44. Presently being treated for any illness	□	□
19. Jaundice	□	□	45. Aware of a change in health	□	□
20. Thyroid or parathyroid disease	□	□	46. Often exhausted or fatigued	□	□
21. Hormone deficiency	□	□	47. Subject to frequent headaches	□	□
22. High cholesterol	□	□	48. A heavy smoker (1 pk or more)	□	□
23. Diabetes	□	□	49. Considered a touchy person	□	□
24. Stomach or duodenal ulcer	□	□	50. Often unhappy or depressed	□	□
25. Digestive disorders	□	□	51. Easily upset or irritated	□	□
26. Arthritis	□	□	52. Female – taking birth control	□	□
27. Glaucoma	□	□	53. Female – Pregnant	□	□
28. Contact lenses	□	□	54. Male - Prostate disorders	□	□
29. Head or neck injuries	□	□			

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

List any medications taken within the last two years _____

_____

Chad A LaCour, DDS
Appointment Agreement

When you schedule an appointment in our office, we have made a commitment to see you for a specific amount of time, depending on the purpose of your visit. Unlike other offices, we do not double book our patients. **Your appointment time is reserved exclusively for you. When scheduling an appointment with us, you are making a commitment to us to be here, and to be on time.**

We understand that emergencies do arise and that an appointment may need to be rescheduled, however, we request that you give us a 48 hour notice.

If an appointment is failed without proper notification, a fee of $75 per scheduled hour in hygiene, and a fee of $250 per scheduled hour in doctor time, will be charged to your account.

If for any reason you are more than 20 minutes late, a $75 fee will be charged to your account, and your appointment will be rescheduled.

Our schedule is the lifeline of our practice, please help us to help you.

I have read, understand, and agree to the terms of the above.

_____ _____

Patient Signature **Date**

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Chad A LaCour, DDS
Financial Policy

It is our desire to provide you, our patient, with the best possible dental care. We have an obligation to you, to do all we can to deliver the highest quality available. In return, we ask that you honor your financial obligations to our office.

If you have dental insurance, we will file claims with all plans. However, certain procedures (including refraction) may not be covered by your insurance plan. If your service or procedure is not covered by your insurance plan, you will be responsible for payment in full at the conclusion of the visit. **PAYMENT FOR COPAYS, DEDUCTIBLES, AND NON-COVERED PROCEDURES IS EXPECTED AT THE TIME SERVICE IS RENDERED.**

We require a copy of your insurance card and a copy of your driver's license.

If any treatment is required, financial arrangements must be made in writing prior to treatment. If no arrangements are in place, payment is due in full at the time of treatment.

Your signature at the bottom of this form signifies that you understand that the service needed may not be a covered benefit under your insurance plan and that you fully accept the fact that the charges incurred are out-of-pocket expenses and will not be reimbursed by your health care plan. **THERE WILL BE A CHARGE OF $25.00 FOR ALL NSF CHECKS. PAST DUE BALANCES AFTER 90 DAYS WILL BE CHARGED A $20.00 DELINQUENT CHARGE AND 1.5% MONTHLY INTEREST CHARGE ON THE UNPAID BALANCE.**

We appreciate your commitment to our office.

I have read, understand, and agree to follow the terms above.

Patient Signature

Date