EDWARD J. HEBERT D.D.S. SCOTT M. HANNAMAN D.D.S.
A PROFESSIONAL DENTAL CORPORATION

Please take a few minutes to fill out this form as complete as you can. *If you have any questions we will be glad to assist you* – the better we communicate, the better we can care for you! We look forward to working with you in maintaining you dental health.

Patient Information (please print all information)

Today's Date: _____ Date of Birth: _____ Social Security #:_____
MM/DD/YYYY

Name: _____Age:_____
Last First MI (nickname)

Address: _____
Street & Apt # City State Zip Code

Home Phone #: _____Cell Phone #:_____ Other Contact #: _____Sex: M__F__

Driver's Lic.#: _____Employer or School Name _____Business phone #: _____

E-Mail: _____ (Only to be used for confirmations and account correspondence)

Preferred Appointment Times: ☐ Morning ☐ Afternoon ☐ Anytime ☐ M ☐ T ☐ W ☐ T ☐ F

Please list all family members who are current or past patients in this office: _____

Who may we thank for referring you to our office: _____

Name and Ages of Children: _____

About Your Spouse:

Name: _____Date of Birth: _____ Is he/she a patient here _____

Person responsible for this Account:

Name: _____ Relationship to patient? _____ Date of Birth: _____

Address: _____
Street & Apt # City State Zip Code

Employer Name: _____Business Phone #: _____ Social Security #: _____

Dental Insurance:

We require a current copy of your Dental Insurance Card in order to file insurance on your behalf.

Name of Insured: _____Date of Birth of Insured: _____

Social Security # of Insured _____ Insured Employed by _____

Relationship to Patient _____ Insurance Company Name _____

Authorization:

I understand that I am financially responsible for all charges whether or not paid by insurance.

I have completed this form truthfully to the best of my knowledge.

I authorize my insurance company to pay to Dr. Edward Hebert, D.D.S. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Edward Hebert, D.D.S and/or Dr. Scott M. Hannaman. to release all information necessary to secure the payment of benefits.

Patient Signature _____ **Date** _____

Responsible Party Signature _____ **Date** _____

EDWARD J. HEBERT D.D.S. SCOTT M. HANNAMAN D.D.S.
A PROFESSIONAL DENTAL CORPORATION

MEDICAL HISTORY CHART

Name: _____
Date of Birth: _____

	Yes	No
Are you in good health at this time?	☐	☐
Are you taking any drugs or medications at this time?	☐	☐
Please list medications: _____		
_____		
Are you receiving any medical treatment at this time?	☐	☐
Have you had any adverse reaction to any drugs including penicillin?	☐	☐
Are you allergic to any known material resulting in – Hives, asthma and/or eczema?	☐	☐
Have you had any recent illness or operations/hospital visits?	☐	☐
Do you have night sweats accompanied by weight loss or cough?	☐	☐
Do you have or ever have had wounds that healed slowly or presented with complications?	☐	☐
Have you ever had x-ray treatments? (other than diagnostic)	☐	☐
Have you ever taken oral bisphosphonates? (e.g. actonel, boniva, fosamax)	☐	☐

Have you ever had or do you have a history of ……

☐ Asthma
☐ Bleeding disorders
☐ Depression
☐ Diabetes
☐ Seizures, Epilepsy
☐ Thyroid Disease
☐ Trench Mouth
☐ Tuberculosis
☐ Hepatitis A B or C
☐ Smoking____Pk/day

☐ Rheumatic Fever
☐ Tumors or Growths
☐ Yellow Jaundice
☐ Heart Ailment
☐ Liver Disease
☐ Rheumatism or Arthritis
☐ Venereal Disease
☐ Respiratory Disease
☐ History of Drug Abuse

☐ Hernia
☐ Kidney Disease
☐ Stomach or Intestinal Disease
☐ Artificial Joints, (screws, rods, or pins)
☐ Shortness of Breath
☐ Hypertension/High blood pressure
☐ Mitral Valve Prolapse/Heart Murmur
☐ Bronchitis, chronic cough
☐ Allergy to Latex

Patient Dental History…….

	Yes	No
Is this your first time to the Dentist?.....	☐	☐
When was your last Dental check up? _____	☐	☐
When was your last Dental Full mouth x-ray taken? _____	☐	☐
Do you at this present time have any dental complaints?.....	☐	☐
Do you have sensitive teeth or bleeding gums?.....	☐	☐
Have you ever had an unfavorable reaction to dental treatment?.....	☐	☐
Have you ever had instruction on the correct method of brushing your teeth?.....	☐	☐
Have you ever had instructions on the care of your gums?.....	☐	☐
Do you chew only on one side of your mouth? If so why? _____	☐	☐
Do you habitually clench your teeth during the night or day?.....	☐	☐
Is any part of your mouth sore to pressures or irritants? (cold, sweets, ect.).....	☐	☐
Do you have pain in or near your ears?.....	☐	☐
Have you ever had an injury to your jaw or face?.....	☐	☐
Do you have any unhealed injuries or inflamed areas in or around your mouth?.....	☐	☐
Does any part of your mouth hurt when clinched?.....	☐	☐
Have you ever had Novocaine anesthetic?.....	☐	☐
Have you ever had any reactions or allergic symptoms to Novocaine?.....	☐	☐
Have you ever had prolonged bleeding following extractions?.....	☐	☐
Have you had difficulties with extractions in the past?.....	☐	☐

Patient Signature: _____ Date: _____

EDWARD J. HEBERT D.D.S. SCOTT M. HANNAMAN D.D.S.
A PROFESSIONAL DENTAL CORPORATION

FINANCIAL AGREEMENT

Patient Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone: _____ Work or Cell Phone: _____

Our office offers the following methods of payment for dental care performed for yourself and your immediate family.

Option #1 I have no Dental Insurance
-Please choose one of the following

- o I elect to pay Cash____, Check____, Visa ____, Mastercard ____, or Discovery _____, on all visits as treatment progresses.
- o I prefer to secure a bank or healthcare financing loan (Care Credit) for the entire amount of the treatment and will make monthly payments to the lending institution.
- o On extensive treatment, I elect to pay 50% on the preparation date and the balance to be due at the end of treatment.

Option #2 I have Dental Insurance with _____ (Company Name)
-Please choose one of the following

- o I elect to pay for treatment in full and have my insurance company reimburse me.
- o I elect to pay my deductible of $_____ and any out-of-pocket expenses on the preparation date (due to lab fees and expenses) and the balance on completion (normally three to four weeks later).
- o On extensive treatment, I elect to pay 50% of my out-of-pocket expenses on the preparation date (due to lab fees and expense) and the balance on completion (normally three to four weeks later)

I AGREE TO THE FINANCIAL RESPONSIBILITY FOR THE TOTAL FEE. PAYMENT OF BALANCE WITHIN 90 DAYS WILL ASSUME NO INTEREST (90 DAYS SAME AS CASH)
I UNDERSTAND AND AGREE TO A 1-1/2% MONTHLY FINANCE FEE ON THE UNPAID BALANCE REMAINING AFTER 90 DAYS.

"I, the undersigned, have read, understand and accept the information contained in this document" "I understand that credit bureau reports may be obtained in case financing of treatment is requested."

_____ _____ _____
Patient Signature Date Practice Administrator

EDWARD J. HEBERT D.D.S. SCOTT M. HANNAMAN D.D.S.
A PROFESSIONAL DENTAL CORPORATION

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand and we are ready to answer and/or explain any of your questions.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms the contemplated dental treatment is _____
_____

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but not limited to, the following:

- Infection
- Bleeding
- Failure of wound to heal
- Injuries to adjacent teeth and/or hard soft tissues
- Parenthesis or numbness of: Tongue, and/or mouth, and/or face
- Fracture of mandible (lower jaw) or Maxilla (upper jaw)
- Opening between mouth and sinus or mouth and nose
- Tooth or fragment in maxillary sinus
- Incomplete removal of tooth
- Dry Socket
- Loss of teeth
- Loss of bone
- Slough (unanticipated loss of hard and/or soft tissue)
- Injury to adjacent structures
- Instrument breakage
- Breakage of root(s) and retained root fragments
- Swallowing and/or aspiration of objects
- Allergic reaction to drugs
- Trismus (Jaw pain or difficulty opening mouth)
- Failure of treatment to accomplish its purpose
- Death (in rare instances)
- Bacterial Endocarditis
- Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

Acknowledgement

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

Signature of patient or guardian _____ *Date:* __/__/____

1540 COUNTRY CLUB ROAD | LAKE CHARLES, LOUISIANA 70605 | 337.474.4892

EDWARD J. HEBERT D.D.S.
SCOTT M. HANNAMAN D.D.S.
A PROFESSIONAL DENTAL CORPORATION

To all our patients;

Welcome! and thank you for selecting our office. The philosophy of our practice is based on the concept of Preventive Dentistry. Our ultimate goal is to preserve your natural teeth for life and maintain your oral health at an optimum level.

It is our desire to provide your dental health needs as *thoroughly* and *comfortably* as possible. Our initial examination appointment is used to obtain complete dental history and clinical examination along with necessary x-rays. *"To see is to know; not to see is to guess."* The more comprehensive the examination, the more intelligently we can recommend the best dental care for you.

From our study of the examination data, we will prepare a treatment plan for your dental health needs so that we can discuss the conditions present and recommend proper therapy. At that time your choice of treatment will be given and arrangements made to proceed.

If at any time you have a question regarding any treatment, fee, or service; please discuss it with us promptly and frankly. We will make every effort to avoid any misunderstandings.

It is basic policy of our staff to be constantly involved in Continuing Dental Education in order to best serve the needs of our patients.

Cordially,

Dr. Edward J. Hebert, Dr. Scott M. Hannaman and Staff

1540 COUNTRY CLUB ROAD | LAKE CHARLES, LOUISIANA 70605 | 337.474.4892