Amy P. Ferguson, DDS, LLC
Family Dentistry
34287 Highway 16
Denham Springs, LA 70706

PATIENT LAST NAME: ______________________ FIRST: ______________ INITIAL: ________

How do you wish to be addressed? ______________ **SSN** ______________ Date of Birth ______________

Address ______________________ City ______________ State ________ Zip ________

Telephone (Mobile) ______________ (Work) ______________ (Home) ______________

Email ____

How did you hear about our practice? ____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Subscriber Name ______________	Subscriber Name ______________
Subscriber ID ______________	Subscriber ID ______________
Date of Birth ______________	Date of Birth ______________
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name ______________	Employer Name ______________
Employer Phone ______________	Employer Phone ______________
Insurance Company ______________	Insurance Company ______________
Insurance Group ______________	Insurance Group ______________
Insurance Phone ______________	Insurance Phone ______________

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: ______________________ First: ______________ Initial: ____

Address *(If different)* ______________________ Date of Birth ______________

City ______________________ State ______________ Zip ______________

Telephone (Home) ______________ (Work) ______________ (Mobile) ______________

Email ______________ **SSN** ______________ **Date of Birth** ______________

EMERGENCY CONTACT

Last Name: ______________________ First: ______________ Initial: ____

Telephone (☐Mobile ☐Work ☐Home) ______________________

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications.

I attest to the accuracy of the information on this page.

Signature ______________________ Date ______________
(Responsible Party, if under 18)

PATIENT REGISTRATION

Amy P. Ferguson, DDS, LLC
Family Dentistry
34287 Highway 16
Denham Springs, LA 70706

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: ______________________ **PATIENT FIRST NAME:** ______________________

DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental visit ____________

Former dentist ______________________ Date of last dental x-rays ____________

Please check if you have/had:	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums swollen, tender or bleeding	☐	☐

	Yes	No
Head, neck, jaw pain, or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Nitrous Oxide	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweets)	☐	☐

How often do you floss? ____________

How often do you brush? ____________

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain ______________________

Have you ever had trouble from previous dental care? ☐Yes ☐No If Yes, please explain ______________________

MEDICAL HISTORY

Physician's name ______________________ Date of last visit ____________

Physician's address ______________________ Blood Pressure ____________

Have you had any serious illnesses or operations Yes ☐ No ☐ If yes, please describe ______________________

Have you ever had a blood transfusion Yes ☐ No ☐ If yes, give approximate dates ______________________

(Women) Are you pregnant? Yes ☐ No ☐ Due date ____________ Nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

Please check if you have/had:	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode _____	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐

	Yes	No
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type ________	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐

	Yes	No
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you currently under the care of a Physician?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin, or other drugs?	☐	☐

If Yes, please specify ______________________

List any medications that you are taking:

____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature ______________________ Date ____________

Reviewed by: ______________________ Date ____________

DENTAL & MEDICAL HEALTH HISTORY

Amy P. Ferguson, DDS, LLC, Family Dentistry
34287 La Hwy 16, Denham Springs, La 70706

Pain Management Disclosure

If you are or have been treated by a ***Pain Management Physician***, it is required by law for you to inform all of your health care physicians, prior to being seen.

- Are you currently being treated by a ***Pain Management Physician***? YES or NO

Physicians Name: ______________________________

Office Phone Number: ______________________________

When was your last visit? ______________________________

- Have you been treated by a ***Pain Management Physician*** *within the past 12 months?* YES or NO

Physicians Name: ______________________________

Office Phone Number: ______________________________

When was your last visit? ______________________________

I attest to the accuracy of the information on this page.

Patient ______________________________ Date ____________________

Witness ______________________________ Date ____________________

Amy P. Ferguson, DDS, LLC, Family Dentistry
34287 La Hwy 16, Denham Springs, La 70706
(225) 667-6889 office (225) 667-6877 fax

Office Financial Policy

We at Amy P. Ferguson, DDS, LLC Family Dentistry are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. In order to assist you with your health care investment, we are providing the following payment options.

INSURANCE: As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co- payments, and non- covered amounts are due at the time services are rendered. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

PAYMENT: Payment is due at the time that services are rendered, unless prior financial arrangements have been made with the front office.
We Accept: CASH, CHECKS, ALL MAJOR CREDIT CARDS, and/or CARE CREDIT.

RETURNED CHECKS: All returned checks are subject to a $25.00 returned check fee. Any unpaid returned checks will be forwarded to the District Attorney for collection.

CANCELLATION POLICY: We know time is valuable and we ask the same consideration for the amount of time we reserve for you appointment. Consequently, we require at least a 24- hour notice, should you not be able to keep your appointment. Notification given less than 24- hours, could result in a charge of $35.00. We Do understand that emergencies happen!!

I have read the above and understand and agree to these terms. I hereby authorize the release of any dental information necessary to process insurance claims. I authorize the payment of insurance benefits to be directly sent to Amy P. Ferguson, DDS, LLC Family Dentistry.

Patient/ Guardian ______________________________ Date ______________

Witness ____________________________________ Date ______________

Amy P. Ferguson, DDS, LLC, Family Dentistry
34287 La Hwy 16, Denham Springs, La 70706

Authorization and Informed Consent to Dental Treatment

State Law requires us to obtain your consent for dental treatment. Please feel free to ask any questions you may have. In general terms, contemplated treatment is: Restorations, Endodontic Treatment, Periodontal Treatment, Implants, Oral Surgery, Bridges/ Crowns, Dentures/ Partials, Teeth Whitening, Botox Injections, TMJ Treatment, Orthodontic Treatment, Oral Exam, Sealants, Oral Cleaning, Oral Sedation, Local Anesthetic, Nitrous Oxide, Etc.

Alternatives to the Recommended Dental Treatment
Any alternatives to the recommended treatment, including no treatment, will be explained to me, as well as the advantages and disadvantages of each. I also agree to ask any questions that I may have.

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

Infections, Bleeding, Failure of wound to heal, Injuries to adjacent teeth or soft tissues, Paresthesia or numbness of tongue, mouth or face, Fracture of Lower jaw or Upper Jaw, opening between mouth and sinus or mouth and nose, Incomplete removal of tooth, Dry socket, Loss of teeth, Loss of bone, Loss of hard or soft tissues, Instrument breakage, Breakage of roots and retained root fragments, Swallowing or aspiration of objects, Allergic reactions to drugs, Jaw Pain or difficulty opening mouth, Bacterial Endocarditis, All risks involved with anesthesia, Swelling, Pain, Thermal Sensitivity, Tooth Fracture, Vomiting, Headache, Fainting, Nausea, Opening into sinus cavity, Additional Oral Surgery, Hospitalization, or further treatment upon complications, Etc.

State law also requires the we specifically advise you that, although rarely occurring, dental treatment or anesthetic may result in: Death, Brain Damage, Paraplegia, Quadriplegia, Loss of Organs, Loss of Function of an Organ, Loss of function of Face, Arms, Legs, and Disfiguring Scars.

Acknowledgment
I have read and understand the information stated above. I have/ will be given ample opportunity to ask any questions that I may have about treatment. I will ask all questions and understand the dental procedure(s) that I will undergo prior to scheduling my appointment. I understand that the success of this treatment and the avoidance of treatment complications depends upon my complying with the instructions, restrictions, and any recommendations, that have been/ will be explained to me. I also understand that I am to notify the dentist immediately of any suspected complications, where further treatment may be discussed or administered, which is not currently anticipated.

I, as the patient/ as the patients legal guardian, authorize and give consent to **Dr. Amy P. Ferguson** and/or assistants of her choice, to perform any dental procedures, including anesthetic, that deem necessary during treatment. I understand the treatment plan to be presented, along with the fees outlining, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. This consent will remain valid until revoked in writing.

Patient Name ______________________________ Date ______________

Patient/ Guardian Signature ______________________________ Date ______________

Witness ______________________________ Date ______________

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34287 La Hwy 16, Denham Springs, La 70706

ACKNOWLEDGEMENT OF PRIVACY PRACTICES PATIENT CONSENT FORM

(NOTICE OF PRIVACY PRACTICES IS AVAILABLE UPON REQUEST)

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

☐ *Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly*
☐ *Obtain payment from third-party payers for my health care services*
☐ *Conduct normal health care operations such as quality assessment and improvement activities*

I am aware that I may receive a copy of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____ Date: ________________

Signature: ____________________________ Relationship to Patient:__________________

AUTHORIZATION TO RELEASE INFORMATION TO OTHERS

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or dental treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ You May Disclose My Information To The Following ☐ Do Not Disclose My Information to Anyone But Me

1. ________________________ Relationship to Patient: ________________ Date: ___________

2. ________________________ Relationship to Patient: ________________ Date: ___________

- -

For Office Use Only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason: ☐ The patient refused to sign ☐ Communication Barriers ☐ Emergency Situation ☐ Other