PATIENT REGISTRATION

Dr. Jonathan B. Turgeon, DDS
Dr. McKenzie W. Holloway, DDS

Patient's Name: **Sex: M / F** **Birthdate: / /** **How did you hear about us?**

Home Address: **City:** **State:** **Zip:** **Cell Phone:**

Please Circle One: Single / Married / Separated / Widow **E-mail Address**: **Home Phone:**

Employer: **Your Soc Sec. #** **Work Phone:**

Are you a full time student? ☐Yes ☐No If *patient is minor we need: Mother's Birthdate:* *Father's Birth Date:*

Person responsible for account:

Name of spouse (Parent if minor) Spouse's (parent's) employer

Spouse's(parent) Soc. Sec. # Work phone

Do you have any Dental Insurance? If so, what Insurance Company:

Phone Number of Insurance Company:

Emergency Contact Name:

Emergency Contact Phone Number:

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you,
  however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- 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, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT/GUARDIAN SIGNATURE _____ **Date:**_____

DENTAL HISTORY

Please check any of the following problems that apply to you.

-Sensitivity (hot, cold, sweet) ⎦
Where? UR LR UL LL

-Headaches, earaches, neck pain ☐
-Jaw joint pain ☐
-Teeth or fillings breaking ☐
-Grinding or clenching teeth ☐
-Bleeding, swollen or irritated gums ☐
-Loose, tipped or shifting teeth ☐

-Bad breath ☐

Do you have or have you had any of the following?

-Dentures ☐
-Partial dentures ☐
-Braces ☐

-Periodontal (gum) treatments ☐

Please share the following dates:

-Your last cleaning ___/ ___
-Your last oral cancer screening ___/ ___
-Your last complete X-Rays ___/ ___

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐

Do you smoke or use chewing tobacco? ☐
How much? For how long?

If I could change my smile, I would: ☐
-Make them whiter ☐
-Make them straighter ☐
-Close spaces ☐
-Replace black metal fillings with tooth colored restorations ☐

-Repair chipped teeth ☐
-Replace missing teeth ☐
-Replace old crowns that don't match ☐

-Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
-Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

⎦ AIDS
⎦ Allergies (Seasonal)
⎦ Anemia
⎦ Arthritis
⎦ Artificial Heart Valve
⎦ Artificial Joints
⎦ Asthma
⎦ Blood Disease
⎦ Bruise Easily
⎦ Cancer
⎦ Chemotherapy
⎦ Diabetes
⎦ Dizziness
⎦ Drug Addiction
⎦ Emphysema
⎦ Excessive Bleeding
⎦ Fainting
⎦ Glaucoma
⎦ Heart Conditions
⎦ Heart Lesions (Congenital)
⎦ Heart Murmur
⎦ Heart Surgery
⎦ Hepatitis A
⎦ Hepatitis B
⎦ Hepatitis C
⎦ High Blood Pressure
⎦ HIV Positive
⎦ Jaundice
⎦ Jaw Joint Pain
⎦ Kidney Disease
⎦ Liver Disease
⎦ Low Blood Pressure
⎦ Mitral Valve Prolapse
⎦ Nervousness/Depression
⎦ Pacemaker
⎦ Phen Fen (1 month +)
⎦ Pregnant Currently
⎦ Radiation (head/neck)
⎦ Respiratory Problems
⎦ Rheumatic Fever
⎦ Rheumatism
⎦ Scarlet Fever
⎦ Seizures
⎦ Stomach Problems
⎦ Stroke
⎦ Thyroid Disease
⎦ Tuberculosis
⎦ Ulcers
⎦ Venereal Diseases
⎦ Other

Do you have any of the following drug allergies?

⎦ Aspirin ☐ Codeine
⎦ Darvon ☐ Erythromycin

Are you under a physician's care? What for?

_____

Are you taking any medications? What?

⎦ Nitrous Oxide
⎦ Percodan
⎦ Local Anesthetic
⎦ Tetracycline

□ Valium
□ Penicillin
□ Sulfa
□ Other

Family Physician **Phone Number**

PATIENT/GUARDIAN SIGNATURE _____ **Date:** _____

ELITE
FAMILY DENTISTRY
JONATHAN B. TURGEON, DDS

2160 Airline Drive Ste B | BOSSIER CITY LA, 71111 | (318) 741-6778

Written Financial Policy

Thank you for choosing Elite Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Our office requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of $500 or more or more, a 35% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $35.00 per hour is charged for patients who reschedule or cancel more than 1 time in a calendar year without 48-hour notice prior to appointment time. Same day cancellations and no shows will be charged $35.00.

There will be a charge of $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, acknowledge that a copy of this office's

Notice of Privacy Practices has been provided for me to read and review.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

⎦ Individual refused to sign
⎦ Communications barriers prohibited obtaining the acknowledgement
⎦ An emergency situation prevented us from obtaining acknowledgement
⎦ Other (Please Specify)

_____
_____
_____
_____