Dr. Danielle D. Muse, D.D.S
217 East Kaliste Saloom Rd. Ste 100
Lafayette, LA 70508
337-232-9937

Thank you for selecting our dental healthcare team! We will strive to provide you with the best dental care possible. To help us meet your every dental healthcare need, please fill out this form completely in ink. If you have any questions or need assistance, please feel free to call our office- we will be happy to assist you.

PERSONAL INFORMATION

Name_______________________________ Social Sec. #_______________________ Birth Date_______________

Wishes To Be Called________________________________ Male Female Minor Single Married

Name of Spouse__________________________________ Address_______________________________________

E-mail______________________________________City/State/Zip_______________________________________

Employer_______________________________________ Occupation____________________________________

Nearest relative to contact in case of emergency: Name_________________________ Phone#________________

Who may we thank for referring you to our office____

RESPONSIBLE PARTY

Name______________________________________ Relationship To Patient______________________________

Birthdate_____________________ Drivers Lic. #_____________________ Social Sec #____________________

Address__________________________________ City/State/Zip____

Employer______________________________________ Occupation_____________________________________

Home Phone___________________________________ Work Phone____________________________________

TELEPHONE INFORMATION

Home Phone_________________ Work Phone________________ Ext._______ Cellular Phone______________

Where do you prefer to receive calls? Home Work Cell #___________________________

When is the best time to reach you? Time_______________________ Days____________________________

PAST DENTAL INFORMATION

Date of last dental visit___________ Are x-rays available Y N Name of former Dentist_______________

Phone number of former Dentist____

Purpose of visit ____
Prophylaxis _______ Consultation _________ 2nd Opinion __________ Toothache _________

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insured__________________________________

Relationship to patient____________________________

Insured's Birthdate________________________________

Soc. Sec. #______________________________________

Employer____

Date Employed___________________________________

Occupation______________________________________

Insurance Company_______________________________

Group #____

Employee/Cert. #__________________________________

Ins. Co. Address__________________________________

Ins. Co. Phone____________________________________

Deductible_______________________________________

Amount Already Used_____________________________

Max. Annual Benefit______________________________

Secondary Insurance

Name of Insured______________________________

Relationship to patient_________________________

Insured's Birthdate_____________________________

Soc. Sec. #___________________________________

Employer_____________________________________

Date Employed________________________________

Occupation___________________________________

Insurance Company____________________________

Group #______________________________________

Employee/Cert. #_______________________________

Ins. Co. Address_______________________________

Ins. Co. Phone_________________________________

Deductible____________________________________

Amount Already Used__________________________

Max. Annual Benefit___________________________

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. **Payment is due at the time services are rendered.** Please check the option which you prefer.

_____Cash _____Personal Check _____Credit Card---_____Visa _____MC _____Am. Exp. _____Discover

_____ Care Credit _______ DFP (Dental Fee Plan) ______I wish to discuss the dental office's policy.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient or parent if minor Date

HEALTH HISTORY

Name ____ Date _____________________________

Date of last health care exam: ________________What was this exam for?_________________________

Have you been hospitalized or had surgery? (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 note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Blood Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	**Joint Replacement? When placed?**	No	Yes
Asthma, COPD or other Lung Diseases	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	Psychiatric Therapy	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	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
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, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes
Mitral Valve Prolapse	No	Yes			

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Serzone® (nefazodone)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Barbiturates (any)	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment 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? 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" or "low blood pressure"?
What is your normal blood pressure? S /D Today: ____________/_______

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine………………………………………... No Yes
b. Penicillin or other antibiotics …………………………………………… No Yes
c. Aspirin, Ibuprofen or Tylenol® …..……………………………………… No Yes
d. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives……… No Yes
e. Latex or Metals No Yes
f. Other (please specify)____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

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 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*

WHAT DO YOU LIKE ABOUT YOUR PAST DENTAL EXPERIENCES?

WHAT DID YOU NOT LIKE ABOUT YOUR PAST DENTAL EXPERIENCES?

WHAT IS MOST IMPORTANT TO YOU ABOUT YOUR:

FRONT TEETH?

BACK TEETH?

GUMS?

FACIAL WRINKLES?

WHAT IS THE FIRST THING YOU WOULD LIKE OUR DENTAL TEAM TO DO FOR YOU?

DO YOU SNORE?

IF YOU HAD A MAGIC WAND? WHAT WOULD YOU DO OR CHANGE ABOUT YOUR SMILE?

Financial Arrangements

I agree to pay Dr. Danielle D Muse for professional services rendered or to be rendered, **at the time the service is performed**.

I understand that any balance past due over 60 days from the first billing date will be subject to an interest charge of 2% per month.

I understand that insurance benefits assigned to Dr. Danielle D. Muse must be paid within 45 days from the date of insurance billing. If the insurance company has not paid within 45 days, I agree to pay Dr. Danielle D. Muse the full balance within the credit limits of the office. Any payment received by Dr. Muse after my balance is paid will be refunded to me. I understand that Dr. Muse's office cannot be responsible for collecting my insurance claim or for negotiating a settlement on a disputed claim. I agree to pay all balances not covered by my insurance carrier.

I understand that any minor (17 or under), when brought into Dr. Muse's office for treatment, should have their estimated portion at that time for services rendered.

I agree to give at least 48 hours notice if I need to change my appointment. I agree to pay $75.00 for the appointment time lost if I fail to keep my appointment without giving notice.

I understand that fee estimates quoted are based on all appointments being kept. Fees quoted will remain valid for 90 days.

I understand that if it is necessary for Dr. Danielle D. Muse to retain the services of an attorney to collect my unpaid balance, I will be responsible for all court costs, attorney's fees and any other collection fees which may be incurred as a result of my account being turned over for collection as allowed by the State of Louisiana.

I agree to pay a fee of $25.00 for any check returned N.S.F., Account closed, etc.

I have read and understand the above

_________________________________ ____________________

SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR DATE

Release of Photos

I do / do not hereby give permission/consent to the use of my pictures and name by Dr. Danielle D Muse, a professional corporation, its employees and agents for advertising, promotion, educational and related purposes.

Patient's Signature:__________________________ Date:_____________

Patient's name (print)_________________________

Witness Signature:___________________________ Date:_____________

Danielle D. Muse, D.D.S
217 E. Kaliste Saloom Rd., Ste. 100
Lafayette, LA. 70508

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private 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. I also understand 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 ____
RELATIONSHIP TO PATIENT ______________________________________
SIGNATURE ____
DATE ____________________________
===

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
DATE:_______________INITIALS:_______REASON:____________________________

HIPAA Release of Information AUTHORIZATION FORM

I, ____________________________hereby authorize *Dr. Danielle Muse, DDS* and its affiliates, its employees and agents, to release to *my current insurance carrier and/or my physician* my personal health information maintained by *Dr. Danielle Muse,DDS* (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

___________________________ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues *and consult with my physician*. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the date I cease being a patient-of-record of *office name.* I understand that I have a right to revoke this authorization by providing written notice to ___________________. However, this authorization may not be revoked if ___________________, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient's Name: ____
Patient Signature:____
Date:____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: ____
Signature of Legal Representative: ______________________________________
Date: ____
Name of Witness: ____
Signature of Witness: ____