DANIELLE DECOU, DDS
&
ASSOCIATES

202 Feu Follet Road
Lafayette, La 70508
Phone: 337-232-9937
Fax: 337-232-1172

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) ◯*one* ◯*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 Decou 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 Decou 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 Decou the full balance within the credit limits of the office. Any payment received by Dr. Decou after my balance is paid will be refunded to me. I understand that Dr. Decou'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. Decou'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 Decou 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, _____hereby give permission/consent to the use of my pictures and name by Dr. Danielle Decou, 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 Decou, D.D.S
202 Feu Follet Road
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 _____
==========

HIPAA Release of Information AUTHORIZATION FORM

I, _____hereby authorize *Dr. Danielle Decou, 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 Decou,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: _____