PATIENT HEALTH RECORD

Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Date of Birth _____ Sex _____ Height _____ Weight _____

Occupation _____ DL# _____ SS# _____ Single ____ Married ____

Emergency Contact _____ Phone _____

How did you hear about us? _____

MEDICAL HEALTH

Are you under a physician's care now?	❍ Yes	❍ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	❍ Yes	❍ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	❍ Yes	❍ No	If yes, please explain: _____
Are you taking any medications, pills or drugs?	❍ Yes	❍ No	If yes, please list: _____
Do you take, or have you taken, Phen-Fen or Redux?	❍ Yes	❍ No	_____
Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphophonates-for osteoporosis?	❍ Yes	❍ No	_____
Are you on a blood thinner?	❍ Yes	❍ No	If yes, name it: _____
Are you on a special diet?	❍ Yes	❍ No	
Do you use tobacco?	❍ Yes	❍ No	
Do you use controlled substances?	❍ Yes	❍ No	

Women: Are you Pregnant?	Are you trying to get Pregnant?	Taking Oral Contraceptives?	Nursing?
❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No

Are you allergic to any of the following?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Local Anesthetics ❍ Acrylic ❍ Metal ❍ Latex ❍ Sulfa Drugs

❍ Other If other, please list: _____

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

AIDS/HIV positive	❍ Yes ❍ No	Cortisone Medicine	❍ Yes ❍ No	Hemophilia	❍ Yes ❍ No	Radiation Treatments	❍ Yes ❍ No
Alzheimer's Disease	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Hepatitis A	❍ Yes ❍ No	Recent Weight Loss	❍ Yes ❍ No
Anaphylaxis	❍ Yes ❍ No	Drug Addiction	❍ Yes ❍ No	Hepatitis B or C	❍ Yes ❍ No	Renal Dialysis	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Easily Winded	❍ Yes ❍ No	Herpes	❍ Yes ❍ No	Rheumatic fever	❍ Yes ❍ No
Angina	❍ Yes ❍ No	Emphysema	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Rheumatism	❍ Yes ❍ No
Arthritis/Gout	❍ Yes ❍ No	Epilepsy or Seizures	❍ Yes ❍ No	High Cholesterol	❍ Yes ❍ No	Scarlet Fever	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No	Excessive Bleeding	❍ Yes ❍ No	Hives or Rash	❍ Yes ❍ No	Shingles	❍ Yes ❍ No
Artificial Joint	❍ Yes ❍ No	Excessive Thirst	❍ Yes ❍ No	Hypoglycemia	❍ Yes ❍ No	Sickle Cell Disease	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Fainting Spells/Dizziness	❍ Yes ❍ No	Irregular Heartbeat	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Blood Disease	❍ Yes ❍ No	Frequent Cough	❍ Yes ❍ No	Kidney Problems	❍ Yes ❍ No	Spina Bifida	❍ Yes ❍ No
Blood Transfusion	❍ Yes ❍ No	Frequent Diarrhea	❍ Yes ❍ No	Leukemia	❍ Yes ❍ No	Stomach/Intestinal Disease	❍ Yes ❍ No
Breathing Problem	❍ Yes ❍ No	Frequent Headaches	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
Bruise Easily	❍ Yes ❍ No	Genital Herpes	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No	Swelling of Limbs	❍ Yes ❍ No
Cancer	❍ Yes ❍ No	Glaucoma	❍ Yes ❍ No	Lung Disease	❍ Yes ❍ No	Thyroid Disease	❍ Yes ❍ No
Chemotherapy	❍ Yes ❍ No	Hay Fever	❍ Yes ❍ No	Mitral Valve Prolapse	❍ Yes ❍ No	Tonsillitis	❍ Yes ❍ No
Chest Pains	❍ Yes ❍ No	Heart Attack/Failure	❍ Yes ❍ No	Osteoporosis	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Cold Sores/Fever Blisters	❍ Yes ❍ No	Heart Murmur	❍ Yes ❍ No	Pain in Jaw Joints	❍ Yes ❍ No	Tumors or Growths	❍ Yes ❍ No
Congenital Heart Disorder	❍ Yes ❍ No	Heart Pacemaker	❍ Yes ❍ No	Parathyroid Disease	❍ Yes ❍ No	Ulcers	❍ Yes ❍ No
Convulsions	❍ Yes ❍ No	Heart Trouble/Disease	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No	Venereal disease	❍ Yes ❍ No
						Yellow Jaundice	❍ Yes ❍ No

Have you any disease, condition, or problem not previously listed? _____

Are you in generally good health _____

Patient Signature or Guardian if Minor _____

Dr. Signature _____

DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot____ Cold____ Sweets_____ Chewing _____

How often do you brush your teeth?_____ Floss?_____ Water Jet? _____

Do your gums bleed while cleaning?_____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment?_____ When?_____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____

Can you chew on both sides of your mouth?_____ Comfortably?_____

Do you have frequent headaches?_____ Earaches? _____

Have you ever had orthodontic treatment (braces)?_____ When?_____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth?_____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth?_____ Food traps? _____

Do you have any missing teeth?_____ Have they been replaced? _____

If so, how? Fixed bridge_____ Removable partial _____ Full denture _____ Dental implant _____

Are you comfortable with the replacement?_____ Please describe _____

_____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your smile's appearance? _____

If yes, are you pleased with the result?_____ Please comment _____

_____

Is there anything else you would like to let us know to make your first visit more comfortable? _____

_____

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

Signature _____

Dr. Signature _____

James L. Jeansonne, DDS Chad S. Spillers, DDS

FINANCIAL POLICY

At Drs. Jeansonne and Spillers' office, the doctors and staff are committed to providing you with the best services and treatment at as low a cost as possible without compromising the quality of treatment. Therefore, we have instituted a financial policy that will help you receive the best dental care you can afford. We will attempt at all times to provide a written **estimate** of charges for your proposed services prior to treatment.

PLEASE READ THE FOLLOWING AND CHECK ONE (A OR B):

☐ **A.** I DO NOT HAVE DENTAL INSURANCE. I UNDERSTAND THAT PAYMENT IS DUE **IN FULL** AT THE TIME OF TREATMENT.

☐ **B.** I HAVE DENTAL INSURANCE AND I UNDERSTAND THE FOLLOWING:

1. IF CURRENT COVERAGE CANNOT BE VERIFIED BY THE END OF YOUR APPOINTMENT, YOU MUST PAY FOR YOUR VISIT IN FULL.
2. ALL DEDUCTIBLES AND ESTIMATED CO-PAYS ARE DUE AT THE TIME OF THE VISIT.
3. **VERIFICATION OF COVERAGE IS NOT A GUARANTEE OF PAYMENT.** REMEMBER: YOUR DENTAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. **REGARDLESS OF YOUR ESTIMATED BENEFITS, YOU ARE ULTIMATELY RESPONSIBLE FOR ALL FEES CHARGED ON TREATMENT PERFORMED.** WE WILL WAIT 45 DAYS FOR INSURANCE PAYMENT. THEREAFTER, THE BALANCE IS TO BE PAID BY YOU.
4. **WE DO NOT ACCEPT INSURANCE ALONE AS PAYMENT.**
5. PLEASE INDICATE:
   POLICYHOLDER'S EMPLOYER:_____
   POLICYHOLDER'S DOB:_____GROUP#_____
   POLICYHOLDER'S ID OR SSN:_____

We do NOT accept out of state checks.

If you have any questions about your insurance coverage, or the proposed fees, please ask the business office before treatment begins. This will eliminate any misunderstandings.

A $30.00 HANDLING FEE WILL BE ASSESSED ON ALL NSF CHECKS.

OUR PATIENTS KEEP THEIR APPOINTMENTS: We try to be considerate of your time so we appreciate your consideration in giving the office a **48 HOUR NOTICE** if you need to cancel or reschedule an appointment. This will enable us to help another patient schedule in the time slot you are vacating.

Patient/Guardian SSN:_____ **Patient/Guardian Drivers' License:**_____

Patient/Guardian Mailing Address:_____

Patient/Guardian Signature:_____ **Date:**_____

James L. Jeansonne, DDS Chad S. Spillers, DDS

NOTICE OF PRIVACY PRACTICES

Attached to this paperwork is a copy or the "Notice of Privacy Practices." It informs you of your privacy rights as our patient. This copy is yours to keep if you wish. Please sign below to acknowledge receipt of Drs. Jeansonne and Spillers' "Notice of Privacy Practices."

If there is a person, or persons, you would like to authorize to access you or your dependents' information please list their names and phone numbers below. If there is no one you would like to authorize please check "None".

☐ NONE

NAME_____PHONE #_____

NAME_____PHONE #_____

NAME_____PHONE #_____

NAME_____PHONE #_____

Patient/Guardian Signature:_____**Date**:_____

TREATMENT INFORMATION AND EXPLANATION OF RISK

WORK TO BE DONE

I understand that the following treatments **may** be performed as part of my comprehensive dental care: Fillings, Anesthesia, Crowns and Bridges, Endodontic treatment, Periodontal treatment, Space Maintainers, Extractions, Bone Grafts, Implants and possible other dental treatment.

FILLINGS

Fillings are procedures in which the dentist removes decayed tooth structure or a faulty restoration and replaces it with composite. I understand that these procedures could cause the teeth to be sensitive to hot and cold as well as chewing. The majority of the times, these sensitivities are temporary and they will go away within one or two weeks. However, there are times the depth of the decay in the tooth is greater than predicted by observation and dental radiographs and the tooth may need pulp treatment or root canal and crown. It is also possible that the pulp might already be infected by bacteria and becomeabscessed at some point after the filling procedure and require extraction. I understand that Drs. Jeansonne, Spillers and their associate(s) cannot guaranteed that the teeth receiving fillings will not need to receive the above mentioned additional procedures and that I will be responsible for payments for any additional treatment needed to restore the teeth if the initial filling procedure does not correct the problem.

DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, vomiting, anaphylactic shock(severe allergic reaction) and/or death.

ANESTHESIA

I realize that there are risks involved in receiving local anesthesia from Drs. Jeansonne, Spillers, their associate(s) and/or the hygienist. Some of these risks include: partial face paralysis, inflamed tissue, trismus, adverse reactions to drugs causing cardiac arrest, stroke, hemorrhage, nerve damage and/or numbness.

CROWN AND BRIDGE

I understand that crowns and bridges are generally placed on teeth with a history of decay, large fillings, or fractures. These teeth have a greater chance of needing root canal therapy at a future date. If this future treatment is necessary, I understand that the fee is not included in the cost of the crown. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off prematurely and need to be re-cemented. I must refrain from eating certain hard, sticky or chewy foods. I understand that I must thoroughly clean my crown and/or bridge daily.

ENDODONTIC TREATMENT

I understand that the purpose of a root canal or pulpotomy is due to deep decay into the pulp of the tooth. A root canal is performed in hopes of saving the tooth from extraction for the purpose of function. However, due to the fact that it is not possible to determine the extent of bacterial infection it is possible that even with Drs. Jeansonne, Spillers, or their associate(s) best efforts, my tooth may become abscessed at some point after the pulp treatment and necessitate extraction.

PERIODONTAL TREATMENT

I understand that periodontal disease is a serious gum infection. If not treated properly it could lead to the spread of infection, bone loss and/or tooth loss. If the condition cannot be treated here, I will be advised

INITIAL HERE_____

to see a periodontal specialist. I also understand that I will be placed on a 3 month, 4 month, or 6 month recall schedule for future hygiene appointments. I understand that without proper brushing and flossing, or if I fail to keep my regularly schedule hygiene appointments, Drs. Jeansonne, Spillers, their associate(s), the hygienist are not responsible for my periodontal health.

SPACE MAINTANIERS

I understand that my child may benefit from space maintainers to prevent loss of space due to extraction or otherwise premature loss of a baby tooth. I understand that space maintainers may become loose or fall off during normal function(especially if my child eats sticky, chewy or hard foods) and may be a potential choking hazard. If the space maintainer becomes loose, I will try to remove it and if I am unable to do so, I will immediately contact Drs. Jeansonne and Spillers' dental office to have it removed. If Drs. Jeansonne and Spillers office is closed and/or it is after hours, I will go to the emergency room to have it removed.

EXTRACTIONS

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) I understand removing teeth does not always remove infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue and surrounding tissues(paresthesia) that can last for an indefinite period of time or a fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. I also understand that after the removal of my teeth I will likely need to replace them by means of implants, full dentures, partial dentures or bridgework to prevent the collapse of my remaining dentition.

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination.

The effect and nature of the procedures which may be performed, and the risks involved as well as the possible alternative methods of treatment have been fully explained to me. I know that the practice of Dentistry and surgery is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment outcome. Alternative and possible bad reactions have been explained to me in detail. Complications such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drug before, during or after surgery, numbness itching or the tongue, lips, teeth tissues, paresthesia, fractured jaw, temporomandibular joint complications, which could cause localized and systemic pain requiring future treatments including joint surgery, etc. can occur.

I certify that I have read and fully understand the above consent to dental treatment and that the explanations therein referred to were made. Anything I did not understand has been explained to me.

Patient/Guardian Signature_____ Date_____

Witness Signature_____ Date_____

Doctor Signature_____ Date_____

EFFECTIVE JAN 5, 2021

Missed Appointment Policy

Our goal is to provide quality care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call the office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 48 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient to access to that appointment time.

How To Cancel Your Appointment

If you need to cancel your appointment, please call us at 225-647-3577. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less that 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $25.00 missed appointment fee.

It is our philosophy to continue to put our patients first and make sure your experience a positive one. Thank you for allowing us to share our appointment policy with you. Please let us know if you have any questions.

Pt Name: _____

Signature: _____

Date: _____