Louis LeFebvre III, DDS
main street
DENTAL CARE

Thank you for visiting Main Street Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP CODE

Employer _____ Driver's License_____

Birth Date_____ Height_____ Weight _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? ☐ Yes ☐No

Mobile (____) _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Dependant/Child

Email address_____

Please circle your preferred contact method for appointment confirmations: Phone call Text

Please circle your preferred contact method for recall appointments: Phone call Text Postcard

Emergency Name and Phone Number: _____(____) _____

Insurance (complete box only if you have dental insurance)

Primary Dental Carrier

Subscriber Name _____ Social Security #_____ DOB_____

Employer_____ Insurance Co._____

Insurance Co Phone_____ Group #_____

Relation to Patient_____

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost and dental treatment.

_____ _____
SIGNATURE DATE

I understand that I am responsible for all costs for dental treatment. I hereby authorize Main Street Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

_____ _____
SIGNATURE DATE

If Patient is under 18:

Responsible Party: _____Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP CODE

Phone _(_____)_____

Medical History and Information

Your current health is: ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment ☐ Yes ☐ No Do your gums bleed? ☐ Yes ☐ No

Are you under stress (new job, moving, relationships)? ☐ Yes ☐ No

How many times do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to hot, cold or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Do you take any bone density medications? ☐ Yes ☐ No

Do you suffer from apthous ulcers or fever blisters? ☐ Yes ☐ No
If so we have a therapeutic laser procedure that can alleviate the pain and future reoccurrence of these lesions at the treated sites.

Please list your personal physician and phone number: _____

Please list any medical specialist(s) and phone number(s) whose care you are presently under:
_____

Please list any surgical procedures you have had in the last 5 years: _____
_____

Have you had any metal rods, pins, prosthetics, screws or implants placed? ☐ Yes ☐ No

Conditions
Please check all that apply:

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Birth Control Pills
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Facial Trauma
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV+/AIDS
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ STD's
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ TMJ Disorders
- ☐ TMJ Pain
- ☐ TMJ Clicking/Popping
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vertigo
- ☐ Ulcers

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Sedatives
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline

Other Allergy
_____

_____

	Yes	No
Do you smoke?	☐	☐
Do you use tobacco?	☐	☐
Do you usually pre-med before your dental visits?	☐	☐

If Female:

Do you suffer from any other conditions/disorders that are not listed above? _____

Please list any medications that you are currently taking: _____

I attest that the information given is true and accurate to the best of my knowledge.

_____ _____
Signature Date

Other Information

How did you hear about us? Please circle one: Mailer Sign/Drive by Internet/Google Internet/Yahoo

Yellow Pages Phonebook AT&T Phonebook Pelican Pages Phonebook

Friend/Referral _____ Other _____

What is the reason for today's visit? _____

Would you be interested in the use of Nitrous Oxide to make your visits easier? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

Have you had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____ When was your last dental x-ray?_____

When was your last dental visit? _____

How can we accommodate you better during your dental visit? _____

Do you love your smile? _____

Here at Main Street Dental Care, we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below that you would like our friendly staff to discuss with you during your visit.

In Office Whitening	Veneers	Implants/Implant Crowns
Take Home Whitening	Crown and Bridge	Smile Makeover
6 Month Braces (Orthodontics)	Night/Sport Guard	Botox
Invisalign	Sealants	Dermal Fillers
Partials/Dentures	Bonding	Botox for TMJ and Pain Management

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient are/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____
Patient's Signature Date

_____ _____
Parent/Guardian Signature Date

Main Street Dental Care

At Main Street Dental Care, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know.....

Your dental benefits are based on a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."**

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Main Street Dental Care reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Main Street Dental Care does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash and checks (for existing patients with established payment history). We **do not accept** checks for over $500.00 for any patient. If you are in need of an extended finance option, we also work with Care Credit, who offers a twelve month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of the patient services staff for an application. A $25.00 fee will be added to your account balance for any returned checks due to insufficient funds, as well as the amount of the returned check.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **at least 24 hour** notice to avoid a **$35/hour cancellation fee** (emergencies are an exception).

After Hours/Weekend Emergencies: In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee.**

We welcome you to our family and look forward to helping you get the healthy, beautiful smile that you have always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print: _____

Sign: _____

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation and/or premedication prior to dental care being rendered. Some of these risks/complications are, but are not limited to the following:

- Infection
- Bleeding
- Failure of wound to heal
- Loss of teeth
- Loss of bone
- Instrument breakage
- Bacterial endocarditis
- Breakage of root(s) and retained root fragments
- Swallowing and/or aspiration of objects
- Failure of treatment to accomplish main purpose
- Trismus (jaw pain or difficulty opening mouth)
- Opening between mouth and sinus or mouth and nose
- Injuries to adjacent teeth and/or hard soft tissue
- Dry socket
- Incomplete removal of tooth
- Injury to adjacent structures
- Allergic reaction to drugs
- Tooth or fragment in maxillary sinus
- Death (in rare instances)
- Parasthesia or numbness of tongue and/or mouth, and/or face
- Fracture of mandible (lower jaw) or maxilla (upper jaw)
- Slough (unanticipated loss of hard and/or soft tissue)

Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s).

ACKNOWLEDGMENT

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienist, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writing.

_____ _____

Signature of patient or guardian **DATE**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 had 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 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 healthcare 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: _____

Please list any individual(s) that you give permission to have access to records (medical & financial): _____

_____

_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this *Notice of Privacy Practices*, but was unable to do so as documented below:

Date:	Initials:	Reason: