PATIENT INFORMATION

Today's Date: Patient's Name: Last First

Home Phone Cell Phone Work Phone

E-mail Address:

Address: City: State: Zip Code:

Date of Birth: *Age: Sex: M F Social Security Number: Marital Status: Please Circle Single, Married, Partner, Separated, Widowed

Emergency Contact: Relationship: Contact Number:

Reason for this Visit: How did you hear about our office? (please list a referring friend by name)

Please list the names of any immediate family members who have been seen at our office:

Responsible Party Name (If under 18 Parent or Guardian Name) Or Circle: Same as Above

Last: First: Relationship to Patient:

Date of Birth: Home Phone: Alternate Phone:

Social Security Number: Employer:

Do you have a primary dental insurance? Y☐ N☐ Name of Insurance:

Do you have a secondary dental insurance? Y☐ N☐ Name of Insurance:

Dental History

What is the name of your last dentist?

How long since your last visit to a dentist?

Have you had periodontal (gum) treatments? Y☐ N☐ How often do you brush your teeth? Floss?

Do you currently have any pain in your teeth? Y☐ N☐ Do your gums bleed easily? Y☐ N☐

Are your teeth sensitive to hot, cold or sweets? Y☐ N☐ Do you have pain in your head, neck or jaws? Y☐ N☐

Are you aware of any grinding or clenching your teeth? Y☐ N☐ Do you wear a night guard? Y☐ N☐

Do you have trouble sleeping? Y☐ N☐ Do you like the way your teeth look? Y☐ N☐

Please check all treatment you're interested in:

- ☐ Braces
- ☐ Bridges/Crowns
- ☐ Cosmetic Dentistry
- ☐ Dental Implants
- ☐ Healthy Gums
- ☐ Invisalign
- ☐ Replacing Missing Teeth
- ☐ Tooth Colored Fillings
- ☐ Veneers
- ☐ Whitening

Please list any other concerns or requests you would like to share with us.

Medical Information

Please CHECK each box YES or NO if you have had or are currently being treated for any of the conditions listed below.

PLEASE CHECK:	YES	NO	PLEASE CHECK:	YES	NO	PLEASE CHECK:	YES	NO
Aids	☐	☐	Excessive Bleeding	☐	☐	Pace maker	☐	☐
Allergies	☐	☐	Fainting	☐	☐	Phen Fen	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Pregnant Currently	☐	☐
Angina Pectoris	☐	☐	Hay Fever	☐	☐	Expected Due Date:		
Arthritis	☐	☐	Heart Disease/Attack	☐	☐	Psychiatric Treatment	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐
Artificial Joints	☐	☐	Heart Surgery	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Hepatitis A	☐	☐	Rheumatism	☐	☐
Blood Disease	☐	☐	Hepatitis B	☐	☐	Scarlet Fever	☐	☐
Bruise Easily	☐	☐	Hepatitis C	☐	☐	Sinus Problems	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Stomach Problems	☐	☐
Chemo Therapy	☐	☐	HIV Positive	☐	☐	Stroke	☐	☐
Congenital Heart Lesions	☐	☐	Jaundice	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Jaw Joint Pain	☐	☐	Tuberculosis	☐	☐
Dizziness	☐	☐	Kidney Disease	☐	☐	Ulcers	☐	☐
Drug Addiction	☐	☐	Low Blood Pressure	☐	☐	Venereal Disease	☐	☐
Emphysema	☐	☐	Mitro Valve Prolapse	☐	☐	Other: ***Please list:***	☐	☐
Epilepsy	☐	☐	Oral Piercings	☐	☐			
Does the patient have any physical, mental, learning or developmental disabilities?				☐	☐	***If yes, please list:***		
Any other special needs that we should be aware of to better help the patient?				☐	☐	***If yes, please list:***		

	Yes	No
Do you use tobacco? (smoking, snuff, chew)	☐	☐
Has a physician recommended that you take antibiotics (as a premedication) prior to your dental treatments?	☐	☐
Are you taking or scheduled to begin taking Bisphosphonates, Fosamax or Actonel for Osteoporosis?	☐	☐
Do you have any disease, condition, or problem not listed above that you think we should know about? --If yes, please list:	☐	☐

ALLERGIES

	Yes	No	Other:
Aspirin	☐	☐	***Please list***
Codeine	☐	☐	
Darvocet	☐	☐	
Erythromycin	☐	☐	
Latex	☐	☐	
Penicillin	☐	☐	
Percocet	☐	☐	
Valium	☐	☐	
Vicodin	☐	☐	

MEDICATIONS *Please list all current medications*:	**PREMEDICATE**	
	Please CHECK if you have ever had any of the following:	**Yes No**
	Artificial Heart Valves	☐ ☐
	A history of infective endocarditis	☐ ☐
	Any serious congenital heart condition	☐ ☐
	Cardiac transplant that develops a problem in a heart valve	☐ ☐
	Any artificial item implanted into your body (in the last two years)	☐ ☐

Physician's Name: _____ Phone: _____

Preferred Pharmacy Name: _____ Phone: _____

THE UNDERSIGNED HEREBY AUTHORIZES ALLURE DENTAL, DR. EVERSGERD AND TEAM TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DR. EVERSGERD TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE DR. EVERSGERD TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY, THAT MAY BE INDICATED. I ALSO UNDERSTAND THE USE OF ANESTHETIC AGENTS EMBODIES CERTAIN RISK SUCH AS PROLONGED TEMPORARY OR PERMANENT NUMBNESS OR TINGLING.

_____

_ Patient/ Guardian Signature **Date Signed**

This authorization will remain in effect for one year from the above date.

Allure Dental
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USEDAND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Allure Dental, is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information, referred to as "PHI," to carry out treatment, payment or office procedures and for other purposes that are permitted or required by law. This notice is effective 12/19/2016. You may access or obtain a copy according to the following options: 1) our website at www.AllureDentalHealth.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

Get an electronic or paper copy of your medical/dental record: You can ask to see or get an electronic or paper copy of your PHI. Ask us how to do this. We will provide a copy or a summary of your health information within 30 days of your request. We may charge a reasonable fee.

Ask us to amend your medical record: You have the right to request we amend your health information that you believe to be incomplete or incorrect. We may deny your request, but we will provide you an explanation in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home, office or cell phone) or to send mail to a different address. We will accommodate all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment or office procedures. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or healthcare item out of pocket, in full, you can ask us not to share that information for the purpose of payment or our operations with your insurance provider.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your PHI for six (6) years prior to the date you ask, who we shared it with and why. We will include all disclosures except for those about treatment, payment and office procedures, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable fee if you ask for another one within twelve (12) months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney, that person can exercise your rights and make choices about your health information. We will make sure that person has authority and can act for you before we take any action.

File a complaint: You can file a complaint if you feel we have violated your child's rights by contacting:

Allure Dental
1901 Hwy 190
Suite 14
Mandeville, LA 70448
Ph: 985-951-2220
www.AllureDentalHealth.com

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20210, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.

We will not retaliate against you for filing a complaint.

In these cases, you have both the right and choice to:

- Share information with your family, friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

If you are unable to tell us your preferences, we may go ahead and share your information if we believe it's in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OTHER USES AND DISCLOSURES: How do we typically use or share your PHI? We typically use or share PHI information in the following ways.

Treatment of your child. We can use your PHI and share it with other professionals who are treating him/her.

Run our practice. We can use and share your PHI to run our practice, improve your care and contact you when necessary.

Bill for services. We can use and share your PHI to bill and get payment from insurance plans or other entities.

How else can we use or share your PHI? We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/concon/index.html

Help with public health and safety issues. We can share PHI about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence and preventing or reducing a serious threat to anyone's health or safety.

Comply with the law. We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with the federal privacy law.

Work with a medical examiner or funeral director. We can share information with a coroner, medical examiner or funeral director when an individual dies.

Address law enforcement and other government requests. We can use or share PHI for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law and for special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions. We can share PHI about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Allure Dental
1901 Hwy 190
Suite 14
Mandeville, LA 70448
PH: 985-951-2220
www.AllureDentalHealth.com

ASSIGNMENT AND RELEASE

I the undersigned, have insurance with _____ and assign directly to Allure Dental, Dr. Eversgerd all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Patient/Guardian Date

PATIENT AGREEMENT AND FINANCIAL POLICY

I hereby agree to be responsible for the costs of care provided by Allure Dental and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, maximums and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor I am responsible for the total amount(s).

I understand that because appointments are not double booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. **For any missed appointment a fee of fifty ($50) dollars may be assessed to my account.** This fee covers the cost of office overhead during the time set aside specifically for me or my dependent(s).

We make every effort to schedule appointments that are the most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than $250 payment in full is due at the time of service. Any payment plans* I agree to wit this office must be completed. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is referred to an attorney, I agree to pay all collection and attorney fees. I am aware that there will be a billing fee of $10 and an 18% per annum finance charge assessed to any account that is more than 90 days old.

_____ _____
Signature of Patient/Guardian Date

MINOR/CHILD CONSENT

I, being the parent or guardian of _____, do hereby request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Signature of Patient/Guardian Date

HIPAA- PATIENT ACKNOWLEDGEMENT FORM

Allure Dental's Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Allure Dental to leave a message or an email regarding an appointment at:

Home: _____and/or

Cell: _____ and/or

Work: _____ and/or

Email: _____

I give permission for Allure Dental to share medical/dental information with:

1. Name: _____ Relationship: _____

   Phone: _____

2. Name: _____ Relationship: _____

   Phone: _____

3. Name: _____ Relationship: _____

   Phone: _____

I assume responsibility to inform the practice of any changes in the above information.

Patient's Name (please print): _____ Date: _____

Signature of Patient or Legal Guardian: _____