PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: Age: _____ Soc. Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Primary Insurance Information

Name of Insured: Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____ .00

Natalie Brasseaux, D.D.S.

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

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 Problems ◯ 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 ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X **Date:**_____

Natalie Brasseaux, D.D.S.

NB Enterprises, L.L.C.
107 Oak Way Lane
Lafayette, LA 70506

Office: (337) 456-3925
Fax: (337) 456-3927

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If this happens, we respectfully ask that prior reserved appointment time be cancelled at least 24 hrs. in advance.

Our providers want to be available for your needs and the needs of all our patients. When a patient does not show up for a reserved appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show, failed and appointments not cancelled within 24 hours.

As of January 1, 2020, there will be a fee of $75.00 assessed if we do not receive a call to cancel an appointment. This fee cannot be billed to your insurance company and will be your direct responsibility.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to the terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature: _____ Date: _____

Important Information And Informed Consent Regarding Our Treatment Plan For You

Natalie Brasseaux, D.D.S., its doctors and staff (the "Practice") provides the following information to you related to your treatment plan.

Your Treatment Plan

The Practice has performed a recent dental examination and advised you of the present condition of your teeth and gums. Based on this exam and discussions with you, the Practice has recommended and presented to you in a separate document a custom-designed treatment plan ("Treatment Plan"), which has the goal of improving the function and/or appearance of your teeth and gums. Your treatment plan involves one or a combination of the following (perhaps along with other recommended dental procedures): periodontal therapy, veneers, crowns, bonding, inlays, onlays, whitening, root canal therapy, gum or tooth contouring. Below are summary descriptions of some of these procedures. You have also been shown photographs of the Practice's recommended procedures for you, heard the Practice's explanations, and/or seen multimedia presentations illustration the primary procedures proposed for your Treatment Plan.

Descriptions of Certain Dental Procedures

Porcelain Veneers are shells of porcelain that are bonded to the teeth. They typically require some roughening or reduction of the outer tooth structure. The Practice doctors will endeavor to minimize the tooth reduction necessary under the circumstances to achieve the desired aesthetic and functional results. At a later visit, the veneers are bonded onto the prepared teeth. The veneers may be designed and fabricated in a variety of shapes and sizes to modify the appearance and function of teeth, including a V-shape that covers the front and backside of the teeth (for example, when opening a bite).

Crowns are life-like looking tooth restorations made out of porcelain or porcelain plus other materials. A crown covers the entire tooth structure. Typically, more tooth structure is removed to prepare for a crown placement than for a veneer. Crowns may be recommended for teeth requiring additional support due to a loss of healthy tooth structure.

Bonding is a term that is commonly used to refer to the placement of composite resins on teeth. Bonding can be used to make a tooth colored filling for small cavities and repair broken or chipped tooth surfaces. It can also be used to close spaces between teeth.

Inlays or Onlays may be the recommended treatment when individual back teeth are broken down but retain enough healthy tooth structure to allow for restoration of certain voids in the tooth structure. The tooth is prepared much like a normal filling or a short crown. The restoration material is custom fabricated out of composite resins, porcelain, or porcelain and gold and bonded into the void.

A Bridge is a replacement made for missing teeth. It is composed primarily out of porcelain, which is bonded to adjacent teeth. These abutment teeth may require some reduction or crowning in order to support the teeth being replaced.

Whitening is performed by applying a peroxide gel to the teeth. This can either be done in our office in an accelerated method or in a take home system. The peroxide reacts with the tooth structure to safely whiten the teeth. Porcelain or composite restorations will not whiten with peroxide.

Root Canal Therapy consists of the removal of the infected or irritated nerve tissue that lies within the root of the tooth. This is a possible risk when tooth structure is removed from a tooth or the tooth receives trauma. Usually in the same visit, the canal where the nerve is located will be reshaped and prepared to accept a special root canal filling material. The root canal is then sealed with a sterile, plastic material.

Tooth Contouring is the reshaping of existing tooth structure by removing small amounts. We give particular attention to the edges of the upper and lower front six teeth, which may be reshaped to create a more aesthetic result.

Gum Contouring is the reshaping of the gum tissue, which is many times done to give a more symmetrical appearance.

Custom Preparation

Each person is unique and presents a different set of circumstances. Some of these circumstances are not revealed until during the procedure itself (for example, decay hidden under old crowns, etc.) or after. Therefore, the exact nature of the tooth and gum preparation for your Treatment Plan may vary somewhat from tooth to tooth and may vary from the general descriptions you have read above or seen elsewhere depending on the amount of decay (if any) present, the shape (e.g., gaps, chips, size) and position (e.g., the amount of rotation, spacing or flaring) of the teeth, and the desired look and function of the final restorations. As a result of these and other reasons, the exact nature and contours of the preparation of your teeth and the resulting restorations cannot be known until they are performed. During the course of treatment, unknown or unforeseen conditions may be revealed that necessitate a modification of the proposed Treatment Plan (e.g., a veneer preparation may become a crown prep). The Practice doctors will exercise their professional judgment to perform a conservative preparation of your teeth and to make other necessary decisions regarding the means, manner and method of any procedures as they deem appropriate to achieve the desired results of the Treatment Plan or as they otherwise deem advisable under the circumstances.

Specific Results Not Guaranteed

The dental procedures above have a very high degree of success in our Practice. Human tissues, however, react differently to dental treatment depending on a variety of factors. Each individual case is different and the exact result for each specific case is difficult if not impossible to guarantee. Thus, as with any branch of medicine or dentistry, the proposed Treatment Plan contains no guarantee of specific results. There are many variables that affect how long restorations or whitening can be expected to last, including general health, maintenance of good oral hygiene, regular dental checkups, etc. Therefore, no guarantees can be made or assumed regarding the longevity of restorations or whitening. If you have been provided a computer generated imaging of your simile, you understand that this is an artificial mechanism to serve as a basis for a discussion of treatment, and in no way provides a warranty or representation of specific results. Natural teeth themselves are not "perfect" and contain certain embrasures, striations, and color variations. The Practice doctors use their artistic skills to specify the shades, coloring, shape, and sculpting of the restorations to make what in their experience are very realistic replicas of teeth. As with any type of artistic endeavor, however, aesthetics is a highly subjective perception. You will be allowed to view and approve the lab fabricated porcelain restorations prior to bonding in. Once restorations are placed, and your approval is given, any redos based on the shade, coloring, shape, sculpting, and/or other aesthetic issues will be at the Practice's sole discretion and at its then current rates. Therefore, you may want to bring a friend or loved one to attend the seat appointment to help approve the restorations.

Alternative Treatments

There are alternative treatments to the Practice's recommended Treatment Plan, which may include, but are not necessarily limited to one or more various combinations of veneers, crowns, bonding, onlays, inlays, whitening, contouring of teeth or gums, bridges, dentures, extractions, root canal therapy, fillings, orthodontics, non-surgical therapy, surgical curettage or cleaning, tooth extractions, implant treatments, as well as other dental treatments. Please make sure you have had an opportunity to ask about these and had them explained to your satisfaction.

Non-Treatment Option

One option is to have no treatment performed. This alternative may entail a number of actual or potential risks, which are difficult or impossible to quantify or predict for specific cases. Some of the risks of non-treatment may include, but are not necessarily limited to, exacerbation of any existing symptoms, deterioration of the aesthetics of function of your teeth, improper biting, tooth, head and/or neck pain, fracturing of teeth, discoloration or staining of your teeth, rotation or movement of teeth, TMJ complications, additional wear of your teeth to the point they are not candidates for reconstruction, loss of teeth, bite problems, poor chewing, loosening of teeth, need for dentures, gum recession, bad breath, inability to perform adequate oral hygiene, abscesses or infection, pain, tooth sensitivity, tooth movements, worsening periodontal condition, deeper pockets, and other oral health problems.

Risks and Inconveniences

Inherent in the Practice's proposed Treatment Plan (as well as with many similar or other dental procedures) are certain actual and potential risks and inconveniences, which vary based on individual circumstances and variations in teeth and gums. These risks and inconveniences may last for a short or an indefinable length of time. They include, but are not necessarily limited to, swelling, pain, tooth sensitivity, bleeding, bruising, discoloration, gum recession, abscesses, the need to repeat all or part of the procedure for unknown reasons, gagging, exposure of crown margins or edges, numbness, gum, bone or teeth inflammation, lisping, speech impediments or speaking difficulties, infections, virus, changes in facial appearance, stretching of the mouth resulting in cracked corners, stiffness of facial muscles, changes in occlusion, tooth mobility, loss of teeth, oral surgery, food impaction, root staining, oral opening restrictions, tissue sloughing, continued periodontal disease, implant rejections, root canal therapy, numbness of lip, chin, and gums, dental neuropathy, temporary or permanent numbness or tingling in the lip, tongue, teeth, gums, chin, cheek or jaw area, nerve problems, paresthesia, joint pain/disorder, need for a night guard, accidental nicks or cuts from dental instruments or needle sticks to the body, injuries to adjacent facial area and teeth, fillings in other teeth, other tissues, sutures, chipping, breaking or loosening of the temporary or permanent restorations, accidentally swallowing or aspiring restorations, materials or dental tools, referred pain to the ear, neck, jaw, or head, temporomandibular joint (jaw joint) problems, nausea, allergic reaction, bone fracture, delayed healing, sinus complications, adverse reaction to drugs, medications, and/or anesthetic (including nitrous oxide), respiratory distress, heart failure, or death. You understand that your condition may be the same, better or worse after treatment. If previously placed dental restorations are in place on teeth, the Treatment Plan may entail additional alterations of tooth structure to properly prepare these teeth for new restorations, and/or other unknown or unspecified problems or risks, which the Practice may or may not have encountered, and which are difficult or impossible to predict or quantify.

Maintenance Obligations

For successful treatment results and to lessen the dangers of complication, you agree to comply with your individualized maintenance program and keep excellent oral hygiene. It is typical to need follow-up visits for occlusal or other adjustments.

You agree to notify the Practice at the soonest possible moment in the event that you experience pain or discomfort that you believe may be related to the Practice treatment. You agree to keep your follow-up appointments and to follow recommended treatments for your Treatment Plan as well as follow other precautions and recommendations that may be provided as part of your pre-op or post-operative instructions.

Sign _____

NOTICE OF PRIVACY PRACTICES

Natalie B Brasseaux D.D.S.
107 Oak Way Lane
Lafayette, LA 70506
337-456-3925 office
337-456-3927 fax

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose you health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts(either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

When a state or federal law mandates that certain health information be reported for a specific purpose;

For public health purposes, such as contagious disease reporting; investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of heath care laws;

Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

Sign _____

Natalie Brasseaux, D.D.S.

107 Oak Way Lane

Lafayette, LA 70506

337-456-3925

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Sign _____