MEDICAL HISTORY

Medical doctor's name _____ Phone Number _____

PLEASE CIRCLE

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why? _____ YES NO

Have you ever been treated or diagnosed with any of the following? **CIRCLE** yes or no next to EACH one.

Abnormal Heart Condition	YES	NO	Fainting	YES	NO	Liver Disease	YES	NO	Stroke	YES	NO
Acid Reflux	YES	NO	Fever Blisters	YES	NO	Mitral Valve Prolapse	YES	NO	Thyroid Disorders	YES	NO
AIDS / HIV	YES	NO	Glaucoma	YES	NO	Mental Disorders	YES	NO	Tuberculosis	YES	NO
Anemia	YES	NO	Hay Fever	YES	NO	Nervous Disorders	YES	NO	Tumors	YES	NO
Angina	YES	NO	Head Injuries	YES	NO	Organ Transplant	YES	NO	Ulcers / Colitis	YES	NO
Arthritis	YES	NO	Heart Disease	YES	NO	Pacemaker	YES	NO	Venereal Disease	YES	NO
Artificial Joints / Valves	YES	NO	Heart Murmur	YES	NO	Psychiatric Problems	YES	NO			
Asthma	YES	NO	Hemophilia	YES	NO	Radiation Treatment	YES	NO	Do you have a tobacco habit?		
Blood Disease	YES	NO	Hepatitis A B or C	YES	NO	Respiratory Problems	YES	NO		YES	NO
Blood Thinners	YES	NO	Herpes	YES	NO	Rheumatic Fever	YES	NO			
Cancer	YES	NO	High Blood Pressure	YES	NO	Rheumatism	YES	NO	Are you pregnant?	YES	NO
Diabetes	YES	NO	Jaundice	YES	NO	Scarlet Fever	YES	NO	Are you nursing?	YES	NO
Dizziness	YES	NO	Jaw Problems	YES	NO	Sinus Problems	YES	NO	Are you taking birth control?		
Epilepsy	YES	NO	Kidney Disease	YES	NO	Stomach Problems	YES	NO		YES	NO

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone Number _____

ALLERGIES

Are you allergic to:

Aspirin	YES	NO	Penicillin	YES	NO
Codeine	YES	NO	Sulfa	YES	NO
Latex	YES	NO	Other _____		
Local Anesthetic	YES	NO	_____		

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

ADDRESS _____ TELEPHONE _____

METHOD OF PAYMENT

☐ CASH ☐ CHECK ☐ DEBIT CARD ☐ CREDIT CARD

☐ CARE CREDIT

WE DO NO BILLING. All balances must be paid in full at the time of service. By signing as responsible party below, you are stating that you understand that any balance left after insurance payments must be paid within 30 days. Failure to pay the balance in 30 days will result in an $8.00 monthly billing charge. In the case of default of payment, you promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form. (Strictly Confidential)

Date _____ Signature _____

CAUSEWAY DENTAL CARE family dentistry

900 N. Causeway Blvd., Metairie, Louisiana 70001 • (504) 835-8741

PATIENT INFORMATION

NAME _____ (LAST / FIRST / M. I.) SEX _____ DATE OF BIRTH _____ AGE _____

NICKNAME _____ S.S. # _____ MARITAL STATUS _____

ADDRESS _____ (STREET / CITY / STATE / ZIP)

TELEPHONE _____ (HOME) _____ (WORK) EXT.# _____ _____ (CELL PHONE)

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? ☐ YES ☐ NO IF YES, PLEASE GIVE NAME _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____ EMAIL _____

DENTAL INSURANCE INFORMATION

INSURED'S NAME _____

INSURANCE CO. (PRIMARY) _____

INSURANCE CO. (SECONDARY) _____

INSURED'S EMPLOYER _____

INSURED'S ID # OR S.S. # _____ DATE OF BIRTH _____

GROUP # _____ TELEPHONE _____

Your dental insurance is your responsibility BUT WE CAN HELP. . . Regardless of what we might calculate as your benefits in dollars, we must stress the fact that you, the patient, are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefits from most insurance companies. This will reduce your immediate out of pocket expenditures. Any estimate is based on limited information obtained from your insurance company. We do not have a contract with your insurance company only you do. We are not responsible for how your insurance company pays its claims. We allow 45 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe _____ YES NO

When was your last dental visit or X-rays? _____

What type of dental care have you had in the past and how do you feel about the results? _____

_____

Are you interested in using nitrous oxide for your dental appointments? ..... YES NO

Have you ever been told you have periodontal disease? ..... YES NO

Have you had any type of gum treatment? ..... YES NO

Do you want to keep your remaining teeth? ..... YES NO

Are you interested in whitening your teeth? ..... YES NO

Are you happy with your smile? ..... YES NO

Is there anything you would like to change? ..... YES NO

How often do you floss? _____ How often do you brush? _____

Name of previous dentist? _____

AUTHORIZATION

I hereby authorize payment directly to DR. ANTHONY TRENTACOSTE, JR. of insurance benefits otherwise payable to me. I understand that I am personally responsible for all costs of dental treatment. I hereby request and authorize DR. ANTHONY TRENTACOSTE, JR. 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 (on the next or separate page provided) are true and correct to the best of my knowledge. If I have any changes in my health, I will inform my dentist.

I am in a legal position to agree to the authorization above and claim responsibility for this patient as well as the payment for all treatment.

X _____ DATE _____

☐ ADULT PATIENT ☐ PARENT ☐ GUARDIAN ☐ OTHER (SPECIFY)

(OVER)