William Chouinard, DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Cell phone :_____ Email address:_____ Circle one: TEXT EMAIL BOTH

Address:_____

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions.

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__ Please explain with dates: _____
Have you ever had a serious head or neck injury? Yes__ No__ Please explain with dates:_____
Are you taking any medications, pills, or drugs? Yes__ No__ Please list: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes__ No__
Are you on a special diet? Yes__ No__
Do you use tobacco? Yes__ No__
Do you use controlled substances? Yes__ No__
Do you need to pre-medicate? Yes__ No__ Please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes__ No__ Taking oral contraceptives? Yes__ No__ Nursing? Yes__ No__

Circle any of the following that you are allergic to:

Aspirin__ Penicillin__ Codeine__ Acrylic__ Metal__ Latex__ Local Anesthetics__

If others, please explain:_____

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

AIDS/HIV Positive	Yes__ No__	Cortisone Medicine	Yes__ No__	Hemophilia	Yes__ No__	Renal Dialysis	Yes__ No__
Alzheimer'sDisease	Yes__ No__	Diabetes	Yes__ No__	Hepatitis A	Yes__ No__	Rheumatic Fever	Yes__ No__
Anaphylaxis	Yes__ No__	Drug Addiction	Yes__ No__	Hepatitis B or C	Yes__ No__	Rheumatism	Yes__ No__
Anemia	Yes__ No__	Easily Winded	Yes__ No__	Herpes	Yes__ No__	Scarlet Fever	Yes__ No__
Angina	Yes__ No__	Emphysema	Yes__ No__	High Blood Pressure	Yes__ No__	Shingles	Yes__ No__
Arthritis/Gout	Yes__ No__	Epilepsy or Seizures	Yes__ No__	Hives or Rash	Yes__ No__	Sickle Cell Disease	Yes__ No__
Artificial Heart Valve	Yes__ No__	Excessive Bleeding	Yes__ No__	Hypoglycemia	Yes__ No__	Sinus Trouble	Yes__ No__
Artificial Joint	Yes__ No__	Excessive Thirst	Yes__ No__	Irregular Heartbeat	Yes__ No__	Spina Bifida	Yes__ No__
Asthma	Yes__ No__	Fainting Spells/Dizziness	Yes__ No__	Kidney Problems	Yes__ No__	Stomach/Intestinal Disease	Yes__ No__
Blood Disease	Yes__ No__	Frequent Cough	Yes__ No__	Leukemia	Yes__ No__	Stroke	Yes__ No__
Blood Transfusion	Yes__ No__	Frequent Diarrhea	Yes__ No__	Liver Disease	Yes__ No__	Swelling of Limbs	Yes__ No__
Breathing Problem	Yes__ No__	Frequent Headaches	Yes__ No__	Low Blood Pressure	Yes__ No__	Thyroid Disease	Yes__ No__
Bruise Easily	Yes__ No__	Genital Herpes	Yes__ No__	Lung Disease	Yes__ No__	Tonsillitis	Yes__ No__
Cancer	Yes__ No__	Glaucoma	Yes__ No__	Mitral Valve Prolapse	Yes__ No__	Tuberculosis	Yes__ No__
Chemotherapy	Yes__ No__	Hay Fever	Yes__ No__	Pain in Jaw Joints	Yes__ No__	Tumors or Growths	Yes__ No__
Chest Pains	Yes__ No__	Heart Attack/Failure	Yes__ No__	Parathyroid Disease	Yes__ No__	Ulcers	Yes__ No__
Cold Sores/Fever Blisters	Yes__ No__	Heart Murmur	Yes__ No__	Psychiatric Care	Yes__ No__	Venereal Disease	Yes__ No__
Congenital Heart Disorder	Yes__ No__	Heart Pace Maker	Yes__ No__	Radiation Treatments	Yes__ No__	Yellow Jaundice	Yes__ No__
Convulsions	Yes__ No__	Heart Trouble/Disease	Yes__ No__	Recent Weight Loss	Yes__ No__		

Have you ever had any serious illness not listed above? Yes__ No__ If yes, please explain: _____

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

GNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

William A. Chouinard, DDS
801 N. Main St.
Sikeston, MO 63801
(573)471-8081

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

O Individual refused to sign

O Communication barriers prohibited obtaining the acknowledgement

O An Emergency situation prevented us from obtaining acknowledgement

O Other (Please Specify)

_____

_____

Dr. William Chouinard Financial Policy

Please read this entire form carefully, then sign and date the bottom, as it defines the financial policies of this practice.

Payment is due at the time services are rendered.

The front desk staff will estimate the amount you owe for procedures the doctor or hygienist has completed or those procedures which are in progress. Remember, this is only an estimate. The actual out-of-pocket expense may be less than or greater than the amount that is estimated and collected. You may be reimbursed or apply the excess to another date of service if we have collected too much.

Insurance Coverage

We accept many different insurance plans. All plans have a unique schedule of covered services depending on what plan you or your employer has purchased. There is no guarantee that services will be covered. You, or the person responsible for this account, will be responsible for payment of non-covered procedures. There may be additional charges to cover the costs of parts or lab fees, depending on the treatments provided and the type of insurance coverage. If you wish, we can send a pre-determination to your insurance carrier. This will give you an estimation of your out-of-pocket expense for your treatment. However, please keep in mind that planned treatment can change, once started, at the discretion of the doctor.

Major Work

Patients receiving major work (examples, but not limited to: crowns, bridges, partials, dentures, implants) must pay half of their portion of the costs to begin treatment. They must have their portion of the costs, including lab fees and parts fees, completely paid off before the work can be delivered or cemented.

Cancellation Policy

Our time is as important as yours. We attempt to schedule as efficiently as possible to reduce waiting time. We require patients to cancel 24 hours prior to the appointment time. We do have a machine available to leave a message when the office is closed. A failed appointment is an appointment that was canceled less than 24 hours prior to or an appointment that was never canceled and no one showed up for. Our office will not reschedule a patient after they have had 3 failed appointments.

Returned Checks

There will be a returned check fee of $30 for a check returned to our office due to insufficient funds. This fee may increase depending on the bank's charges. This fee will be added to the outstanding balance and may incur finance charges if not paid within the 30 day grace period. The ONLY acceptable forms of payments for returned checks are cash or money orders.

Medicare Policies

Due to the complexity of the Medicare dental policies, payment is required on the date of service. Our office will be happy to give you a detailed invoice of your procedures performed for you to submit for reimbursement, if the procedures are covered by your plan.

Patient/Responsible Party Signature:_____ Date:_____