

We appreciate your interest in Oak Park Dental!

Please check ALL that apply, so that we can continue to better serve you and thank those who referred you!!!

My primary reason for my visit today is:

- I'm in pain I'm here for a check-up I'm new in town
- My insurance company said that I had to use this dentist
- I wanted to establish myself as a patient with your practice
- I would like to talk to someone about enhancing my smile

I am interested in:

- Full Orthodontics 18-24 month treatment Veneers
- 6 month orthodontics to straighten front teeth Lumineers
- Bleaching: Take home trays or light activated-Zoom Dentures/Partials
- White Fillings A snore appliance
- I suffer from migraine headaches Something to stop my teeth-grinding

I saw your advertisement...

- on KPLC on a billboard I walked in or drove by on the internet
- on the radio the Yellow Pages in the newspaper

I was referred by...

- Dr. _____ @ _____ Current Patient: _____
- Former Patient: _____ Family/Friend: _____
- Acadian Dental / Dr. Short's Office My Insurance Company
- My Co-Worker: _____ A local Business: _____

Welcome to Oak Park Dental

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS# _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Female Male Birthdate _____ Email _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at Home Work Cell No Preference

Married Widowed Single Separated Divorced

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ St _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone(____) _____

Whom may we thank for referring you to us _____

Person to contact in case of emergency _____ Phone(____) _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone(____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone(____) _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date _____

Employed _____

Name of employer _____ Work Phone(____) _____

Insurance Co. _____ Group# _____ Employer# _____

DO YOU HAVE ADDITIONAL INSURANCE Yes No **IF YES PLEASE COMPLETE THE FOLLOWING:**

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date _____

Employed _____

Name of employer _____ Work Phone(____) _____

Insurance Co. _____ Group# _____ Employer# _____

**Payment is due at time of service. The estimate we give you is an estimate only, any portion the insurance does not pay is your responsibility. I understand and agree with the above statement..

Signature & Date: _____

MEDICAL HISTORY

For New Patient

Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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. Thank you for answering the following questions.

Are you under a physician's care now? Yes Please explain: _____

Have you ever

been hospitalized? Yes Please explain: _____

had a major operation? Yes Please explain: _____

had a serious head/neck Injury? Yes Please explain: _____

Are you taking any medications? Yes Please explain: _____

Do you take or have you taken Phen-Fen/Redux? Yes Please explain: _____

Are you on a special diet? Yes Please explain: _____

Do you use tobacco? Yes Please explain: _____

Do you use controlled substances? Yes Please explain: _____

WOMEN ONLY:

Are you:

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

Are you allergic to any of the following:

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Please check if you have, or have had any of the following:

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

Have you ever had any serious illness not listed above? Please Explain _____

To the best of the 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 changed in medical status.

Signature of Patient, Parent, or Guardian _____ Date: _____

Dr. Harry K. Castle

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

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

In general terms, contemplated dental treatment includes:

Periodontal Treatment/Surgery, Root Canal Therapy, Composite or Amalgam Therapy, Crown and Bridge Care, Partial or Denture Care, Local Anesthesia, Nitrous Oxide Sedation, Oral Surgery/Extraction

Alternatives to the Recommended Dental Treatment

Any alternatives to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

Risks Associated with the Recommended Dental Treatment

I understand dentistry is not an exact science and complications may occur despite our best efforts. A partial listing of the risks known to be associated with the dental treatment and the anesthetic are: Infection, Injuries to adjacent teeth and/or hard or soft tissue, Opening between mouth and sinus or mouth and nose, Dry Socket, Slough-unanticipated loss of hard and/or soft tissue, Breakage of root(s) and retained root fragments, Trismus- jaw pain or difficulty opening mouth, Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complications, Bleeding, Paresthesia or numbness of: tongue, and/or mouth, and/or face, tooth or fragment in maxillary sinus, Loss of teeth, Injury to adjacent structures, Swallowing and/or aspiration of objects, Failure of treatment to accomplish its purpose, Failure of wound to heal, Fracture of mandible (lower jaw) or maxilla (upper jaw), Incomplete removal of tooth, Loss of bone, Instrument, Breakage, Allergic reactions, Bacterial Endocarditis. State Law also requires that we specifically advise you that although rarely occurring, the dental treatment or anesthetic may result in: Death, Brain Damage, Quadriplegia, Paraplegia, Loss of Organ(s), Loss of Function of an organ, Loss of function of face, Arm(s), or Leg(s) and Disfiguring Scars.

Acknowledgment

The risks, benefits, and possible complications of the proposed treatment, including the risk that such treatment may not accomplish the desired objective, have been fully explained to me and I fully understand them. I understand that the success of the dental treatment cannot be determined in advance and I acknowledge that no guarantees have been made to me regarding the results of this treatment. I acknowledge that I have read and understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given adequate opportunity to ask whatever questions I have about the treatment, all of the questions about the treatment have been answered in a satisfactory manner. I understand the success of this treatment and avoidance of treatment complications depend to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following the instructions given to me, and keeping the appointments for treatment or follow-up visits rescheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complications where future treatment may be discussed, which is not currently anticipated. I hereby authorize and direct Dr. Harry K. Castle and/or his associates or assistants of his choice, to perform the diagnostic, surgical, or dental procedures, including any necessary or advisable anesthetic. This Consent Form will remain valid until revoked by me in writing.

For Women:

Informed Consent regarding antibiotics effect on oral contraceptives

I understand that women of childbearing age may experience reduced efficiency of oral contraceptives during antibiotic therapy. I understand the need to use additional contraceptives during the antibiotic usage. I understand that I may need to consult my physician about the possibility of higher doses of oral contraceptives and/or other contraceptive alternatives.

Date_____

Signature of Parent/Guardian_____

OAK PARK DENTAL

CONSENT OF DISCLOSURE

I hereby give consent to Oak Park Dental to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy.

Print Name of Patient: _____

Sign: _____ Date: _____

If you are signing as the patient's representative:

Print your Name: _____

Relationship: _____

CANCELLATION

I hereby void the consent given above.

Print Name of Patient: _____

Sign: _____ Date: _____

If you are signing as the patient's representative:

Print your Name: _____

Relationship: _____

Address for cancellation: Your cancellation will be effective, upon receipt, at the following address:

Oak Park Dental
1616 West McNeese
Lake Charles, LA 70605

Cancellation Policy

Welcome to Oak Park Dental! From the beginning we try to establish open lines of communication. Communication is very important, so that you understand us and we understand you. First and foremost we want to make you aware that our office policy states that **you MUST call our office to cancel an appointment at least 24 hours before the scheduled appointment.** If you do not cancel your appointment at least 24 hours before you are scheduled to come in the following charges will be applied to your account:

Dr. Castle: \$75.00/ Hour

Dr. McGee: \$50.00/ Hour

Hygienist: \$50.00/ Hour

Orthodontics \$25.00/Hour

We will also call you to remind you of your appointment either one or two days in advance. If we leave a message, please return our call. We could be calling for different reasons; a time/schedule change or confirmation call. **We must have verbal confirmation from you in order to keep the appointment or it can be cancelled without notice.**

I have read the above office policy and agree to pay for these changes if I do not cancel an appointment 24 hours in advance. I'm also aware that if I do not verbally confirm my appointment that it may be cancelled.

Signature: _____

Date: _____