GEAUXSMILES
HUNG HOANG DDS AND ASSOCIATES

Geaux Smiles - Gretna
406 Lafayette St.
Gretna, LA 70053
(P) (504) 366-3052
(F) (504) 366-9201

Geaux Smiles – Marrero
931 Westwood Drive, Ste I
Marrero, LA 70072
(P) (504) 340-9207
(F) (504) 340-1601

New Patient Registration

Date: ____

Name: ____ Nickname: _________________________

Address: ____________________________City: ____________State: _____ Zip: _________________

Phone: (______) ______________ Email: ____

Date of Birth: _______/_______/_______ Social Security Number: __________-________-________________

Status: ☐ Minor ☐ Single ☐ Married ☐Widowed ☐ Separated ☐Divorced

Whom may we thank for referring you to us? ☐ Phone Book ☐ Website ☐ Facebook ☐ Twitter ☐ Instagram

☐ Google ☐ Yelp ☐ Insurance ☐ Signage ☐ Other ______________ ☐ Individual ______________________

Emergency Contact

Emergency contact:

____

Relationship: __________________________

Phone (______) _________________________

Preferred Pharmacy

Pharmacy:

____

Location: ______________________________

Phone (______) _________________________

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

☐ Other: _______________________________

Name: _________________________________

☐ Same as above

Address: _______________________________

City: ____________State: ____ Zip: __________

Phone: _________________________________

Social Security Number: __________________

Insurance Information

Insured

Name: _________________________________

Date of Birth: __________SSN: ______________

Phone: (______) _________________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

☐ Other: _______________________________

Employer

Name: _________________________________

Address: _______________________________

City: ____________State: ____ Zip: __________

Work (______) ___________________________

Primary Insurance Company

Insurance Company: ______________________

Group Number: __________________________

Member ID/SSN: _________________________

Insurance Phone: ________________________

Secondary Insurance Company

Insurance Company: -______________________

Group Number: __________________________

Member ID/SSN: _________________________

Insurance Phone: ________________________

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Medical History

Patient Information

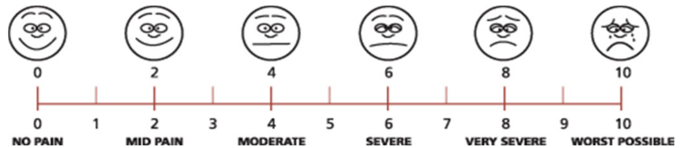
Name: ____ Date of Birth: _______/_______/_______

Dental History

Previous Dentist: ______________________________________ Last Visit: _______/_______/_______

Currently experiencing pain? Yes No

If yes, indicate pain level: _____



	Yes	No	Unsure
Do you bleed excessively after tooth extractions?			
Have you had pain or swelling for more than two weeks after surgery to the jaw?			
Any serious reactions to local/general anesthetics, nitrous oxide?			
Have you ever had serious trouble associated with any previous dental treatment?			
Do you have any soft tissue sores or bumps in your mouth?			
Do you clench or grind your teeth?			
Are any teeth sensitive to cold or sweets?			
Has a doctor told you to take antibiotics BEFORE having dental treatment?			

Medical History

	Yes	No	Unsure
Are you being treated by a medical doctor now?			
Reason: Physician's Name:			
Are you taking any medications at the present time?			
List:			
Have you ever taken medication to relieve anxiety or depression?			
Sensitive or allergic to any medication/products?			
List:			
Have you ever been hospitalized or had any surgical operations?			
Ever had excessive bleeding from a cut or wound?			
Have you ever had cancer? If yes, what kind?			
Do you have pain in the chest upon exertion?			
Shortness of breath after mild exercise or exertion?			
Do your ankles swell or do you bruise easily?			
Use extra pillows to help you breathe better while sleeping?			
Do you have to urinate frequently?			
Are you thirsty and/or hungry much of the time?			
Have you lost or gained weight in the last year? Reason:			
Has a doctor ever said you had infectious diseases (ex: HIV, hepatitis C)			
Do you have difficulty with swallowing, breathing, or snoring?			
Do you have frequent infections?			
Do you have frequent headaches or migraines?			
Do you currently or have you in the past used tobacco products/alcohol?			

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Cardiovascular

	Yes	No	Unsure
Heart failure			
Heart attack or disease			
Angina Pectoris or chest pains			
Acute coronary syndrome			
High blood pressure			
Heart murmur			
Mitral valve prolapse			
Rheumatic fever			
Congenital heart defect or lesion			
Irregular heart beat			
Heart pacemaker or defibrillator			
Heart surgery or transplant			
Other heart problems			
Stroke			
Aneurysm			

Blood/Oncology

	Yes	No	Unsure
Blood transfusion			
Anemia			
Sickle cell disease			
Leukemia			
Clotting disorder or hemophilia			
Tendency to bleed longer than normal			
Chemotherapy			
Radiation treatment			

Endocrine

	Yes	No	Unsure
Diabetes			
Thyroid disease			
Steroid therapy			

Neural/Psychiatric

	Yes	No	Unsure
Eye pain			
Vision problems			
Glaucoma			
Earaches/ringing in ears			
Hearing loss			
Severe headaches			
Fainting or dizzy spells			
Epilepsy, seizures, or convulsions			
Nervousness			
Psychiatric treatment			
Depression			
Schizophrenia			
Bipolar			
Alcohol or substance abuse			

Gastrointestinal

	Yes	No	Unsure
Gastritis/ulcers/reflux disease			
Ulcerative colitis			
Crohn’s disease			
Persistent diarrhea/constipation			
Hepatitis			
Liver disease			
Yellow jaundice			
Cirrhosis			

Respiratory

	Yes	No	Unsure
Chronic bronchitis			
Emphysema			
Asthma			
Respiratory allergies			
Chronic cough			
Sinus trouble			
Tuberculosis (TB)			
Breathing difficulties			
Flu-like symptoms			

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Skin/Mucosa/Musculoskeletal

	Yes	No	Unsure
Allergy to latex (rubber gloves)			
Skin rash			
Dark mole(s) or recent changes			
Melanoma			
Fibromyalgia			
Sore muscles			
Stiff joints			
Arthritis or gout			
Artificial joint			
Osteoporosis			
Medicines for osteoporosis/bone cancer			
Intravenous (IV) bisphosphonates			

Genitourinary

	Yes	No	Unsure
Sexually transmitted disease (STD)			
Kidney(renal) dialysis			
Kidney/bladder problems			
Urinate frequently			

Oral Medicine/Facial Pain

	Yes	No	Unsure
Mouth ulcers or fungus (candidiasis)			
White/red patches in the mouth			
Dry mouth or burning tongue			
Pain in facial muscles			
TMJ problems			
Nerve pain			
Autoimmune disorders			

Other Conditions

	Yes	No	Unsure
Enlarged lymph node or gland			
Head and neck cancer			
Hyperbaric oxygen therapy			
Organ or cell transplant			
Disease, problems, or condition not listed			
List:			

Females

	Yes	No	Unsure
Are you pregnant?			
Do you plan to become pregnant soon?			
Did you have any complications during pregnancy?			
Do you have trouble with your period?			

To the best of my knowledge all the answers on all pages are true and correct. If I have a change in my health information, I will inform my dentist at my next appointment.

Signature of patient, legal guardian, representative

Date

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Office Policies

1. **WE REQUIRE 24 HOUR NOTICE FOR CANCELLATIONS**

   We have scheduled your appointment for you alone. We do not double book appointments. Therefore, a broken appointment fee of $25 will be charged without a 24 hour notice. If a patient no-show their appointment, we have the right to discharge you from our practice.

2. **PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT**

   If you have dental insurance, you will be expected to pay the estimated co-payment at the time of treatment. Full payment is required of emergency and walk-in patients before treatment is rendered.

3. **NSF CHECKS**

   NSF checks returned to us will automatically mean a charge to the patient account of $25. The patient will be responsible to replace the amount of the check in addition to the $25 Non-Sufficient Funds amount.

4. **WE PREPARE INSURANCE FORMS AS A COURTESY TO YOU**

   You are responsible for necessary insurance forms and for payment of all estimated co-payments at the time of service. Remember that payment of all fees is the responsibility of the patient or person responsible for the account.

5. **INSURANCE CO-PAYMENT ARE ESTIMATES**

   Estimated co-payments are not guarantees of insurance payment. Depending on the actual insurance benefit, you may be responsible for the more or less of the fees.

6. **LET US KNOW OF ANY INSURANCE CHANGES**

7. **DEFAULT IN PAYMENT**

   All collection fees, attorney fee, court cost and any other expenses will be paid by the undersigned if there is any default in payment of this account.

8. **CAMERA SURVEILLANCE**

   For the safety of our patients and team members, we employ camera surveillance equipment for security purposes in public areas.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICIES.

____
Signature of patient, legal guardian, representative

____
Date

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GENERAL CONSENT

I consent to be a patient at Geaux Smiles and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with doses, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover. All balances over 90 days will be sent to collections.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I will show up on time for my appointments. Any cancellations will be made at least 24 hours prior to my appointment. Failure to notify the office of cancellations at least 24 hours before the appointment or not showing up to the appointment may be subject to a charge of $25 or denial of future appointments.
7. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.
8. I understand that there are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedication prior to dental care being rendered. Some of these risks/complications are, but not limited to, the following:

- Infection, inflammation, swelling, sensitivity, and/or pain
- Bleeding
- Failure of wound to heal
- Injuries to adjacent teeth and/or hard or soft tissues
- Slough (unanticipated loss of hard and/or soft tissue)
- Injury to adjacent structures
- Instrument breakage
- Breakage of root(s) and retained root fragments
- Swallowing and/or aspirations of objects

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- Paresthesia or numbness of: tongue, and/or mouth, and/or face
- Fracture of mandible (lower jaw) or maxilla (upper jaw)
- Opening between mouth and sinus or mouth and nose
- Tooth or fragment in maxillary sinus
- Incomplete removal of tooth
- Dry socket
- Loss of teeth
- Loss of bone
- Allergic reactions to drugs
- Trismus (jaw pain or difficulty opening mouth)
- Failure of treatment to accomplish its purpose
- Death (in rare instances)
- Bacterial Endocarditis
- Changes in bite or difficulty in opening because of stress on jaw joint (TMJ)
- Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

Signature of patient, legal guardian, representative ______________________ Date ______________________

No Show/Late Cancellation Policy

This Policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-show and late cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of healthcare to other patients.

A no-show is missing a scheduled appointment. A late cancellation is canceling an appointment without calling us to cancel 24 hours in advance of a scheduled appointment.

We understand that situations, such as medical emergencies, occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A Charge of $25 will be assessed for each no show or late cancellation office visit appointment if less than 24-hour notice is given. We have the right to discharge you from our practice due to repeated late cancellations or missed appointments. Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE NO SHOW/CANCELLATION POLICY.

Initials ______________ Date ______________

Email & SMS Communication Release

Due to the changing world of healthcare and technology, we now have the ability to provide our patients with certain types of information via e-mail and/or text messaging.

We believe strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from us via email or text messaging. We do not share the names, e-mail addresses, and/or telephone numbers of patients with any other companies, or with any other patient.

By placing my initials and date below, I acknowledge that I have read and understand the above statement on emails and text messages. I hereby give permission to send messages to me via email and/or text messaging as means of communication.

Initials ______________ Date ______________

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Photography Release

I hereby authorize Hung Hoang, DDS and/or his Associates to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Initials ____________ Date ____________

Patient Acknowledgement of Billing and Estimation Policy

I agree that I am ultimately responsible for charges resulting from dental treatment and diagnosis by the professionals at Geaux Smiles.

I agree that I am responsible for providing up-to-date and accurate information to Geaux Smiles.

Furthermore, I am responsible for making sure that any changes to my insurance are promptly given to the staff at Geaux Smiles. I am responsible for understanding my insurance policy, including all clauses (i.e., missing tooth, alternate benefit as it applies to tooth-colored fillings and crowns), which may affect reimbursement.

I agree to pay the estimated patient's portion of any charges at the time of dental treatment and diagnosis. I also agree to pay any and all charges resulting from dental treatment and diagnosis that are not covered by insurance.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE BILLING AND ESTIMATION POLICY.

Initials ____________ Date ____________

Notice of Privacy Practices (HIPAA) Patient Consent Form

Geaux Smiles' Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The notice contains a Patient's Right section describing your rights under the laws. You have the right to review Geaux Smiles' Notice before signing the consent. The terms of Geaux Smiles may change. If Geaux Smiles changes its notice, you may obtain a revised copy by contacting Geaux Smiles.

You have the right to request that Geaux Smiles restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor this agreement.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

Initials ____________ Date ____________