Dr. Samuel R. Moss, D.D.S.
(337) 232-9937
217 East Kaliste Saloom Rd. Ste. 100
Lafayette, LA 70508

Thank you for selecting our dental healthcare team! We will strive to provide you with the best dental care possible. To help us meet your every dental healthcare need, please fill out this form completely in ink. If you have any questions or need assistance, please feel free to call our office- we will be happy to assist you.

PERSONAL INFORMATION

Name________________________________ Social Sec. #___________________ Birth Date_____________

Wishes To Be Called_________________________________ Male Female Minor Single Married

Name of Spouse_______________________________ Address____

E-mail____________________________________ City/State/Zip______________________________________

Employer_____________________________________ Occupation______________________________________

Nearest relative to contact in case of emergency: Name______________________Phone#___________________

RESPONSIBLE PARTY

Name____ Relationship To Patient___________________________

Birthdate____________________ Drivers Lic. #____________________ Social Sec #____________________

Address____________________________________ City/State/Zip______________________________________

Employer_____________________________________ Occupation______________________________________

Home Phone__________________________________ Work Phone______________________________________

TELEPHONE INFORMATION

Home Phone________________ Work Phone_________________ Ext._______ Cellular Phone____________

Where do you prefer to receive calls? Home Work Cell #_________________________________

When is the best time to reach you? Time_______________________ Days_____________________________

PAST DENTAL INFORMATION

Date of last dental visit___________ Are x-rays available Y N Name of former Dentist_________________

Address of former Dentist________________________________Phone number of former Dentist____________

Purpose of visit _____ toothache / _____pain ______where / _____swelling ______where /

_____ lost filling ______where / _____broken tooth _____where
_____prophylaxis _____second opinion _____consultation

Who may we thank for referring you to our office____

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DENTAL INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Name of Insured________________________________	Name of Insured______________________________
Relationship to patient___________________________	Relationship to patient__________________________
Insured's Birthdate_____________________________	Insured's Birthdate___________________________
Soc. Sec. #____________________________________	Soc. Sec. #__________________________________
Employer______________________________________	Employer____________________________________
Date Employed_________________________________	Date Employed_______________________________
Occupation____________________________________	Occupation__________________________________
Insurance Company______________________________	Insurance Company____________________________
Group #______________________________________	Group #____________________________________
Employee/Cert. #________________________________	Employee/Cert. #______________________________
Ins. Co. Address_________________________________	Ins. Co. Address______________________________
Ins. Co. Phone__________________________________	Ins. Co. Phone_______________________________
Deductible_____________________________________	Deductible__________________________________
Amount Already Used____________________________	Amount Already Used_________________________
Max. Annual Benefit______________________________	Max. Annual Benefit__________________________

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. **Payment is due at the time services are rendered.** Please check the option which you prefer.

_____Cash _____Personal Check _____Credit Card---_____Visa _____MC _____Am. Exp. _____Discover

_____ Care Credit _______ DFP (Dental Fee Plan) ______I wish to discuss the dental office's policy.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of Patient or Parent if Minor Date

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HEALTH HISTORY

Name ____ Date ________________________________

Date of last health care exam: ________________What was this exam for?____________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:____

Are you currently receiving care? No Yes If yes, nature of care: __________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

____
____
____
____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy/ Seizures	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement/ If yes, when	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes	Herbal supplements?	No	Yes
Have you been treated with Bisphosphonate drugs?				No	Yes

Fen-Phen No Yes If yes, did you have a Medical exam for
Heart issues____________ Pondimen No Yes
Redux No Yes

Please list any medications you are currently taking:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes If yes, what is it usually: S /D

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HEALTH HISTORY
(Continued)

Are you allergic or have you had a reaction to:

Local anesthetics ……………………………………………………...	No	Yes
Penicillin or other antibiotics ……………………………………………	No	Yes
Aspirin ….………………..…………………………………………...	No	Yes
Codeine, valium or other sedatives………………………………….…	No	Yes
Other ____		

Are you a smoker? No Yes If so, how much do you smoke per day? ____________________

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes
Do you take Antacids? No Yes If yes, which ones?_____________________________________

Weight: __________

Diet: Restricted Diet ___________________________________
How many meals a day ____________________________
Food Allergies ___________________________________
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:
____
____

Significant findings from questionnaire or oral interview:
____
____

Dental management considerations:
____
____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____________________________ ___________________________ _________________
Patient (Print Name) Patient Signature Date

_____________________________ ___________________________ _________________
Doctor (Print Name) Doctor Signature Date

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INFORMATION UPDATE

Have you had a change in your health since your last visit? No Yes

Heart (Surgery, Disease, Attack)	No	Yes	Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Rheumatic Fever	No	Yes
Joint Replacement	No	Yes	H.I.V. Infection/AIDS	No	Yes
Taken Fen-phen or other diet pills	No	Yes			

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes Are you a nursing mother? No Yes

Please list any medications you are currently taking:
1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
Do you have any allergies? ? No Yes List: ____

Notes: ____
____
____

Signature ____ Date ______________________

Signature ____ Date ______________________

Signature ____ Date ______________________

WHAT DO YOU LIKE ABOUT YOUR PAST DENTAL EXPERIENCES?
____
____

WHAT DID YOU NOT LIKE ABOUT YOUR PAST DENTAL EXPERIENCES?
____
____

WHAT IS MOST IMPORTANT TO YOU ABOUT YOUR:
____
____

FRONT TEETH?
____

BACK TEETH?
____

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INFORMATION UPDATE
(Continued)

GUMS?

____

WHAT IS THE FIRST THING YOU WOULD LIKE OUR DENTAL TEAM TO DO FOR YOU?

____
____

DO YOU HAVE ANY OTHER CONCERNS?

____
____

IF YOU HAD A MAGIC WAND? WHAT WOULD YOU DO OR CHANGE ABOUT YOUR SMILE?

____
____

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FINANCIAL AGREEMENT

I agree to pay Dr. Samuel R. Moss for professional services rendered or to be rendered, ***at the time the service is performed****.*

I understand that any balance past due over 60 days from the first billing date will be subject to an interest charge of 2% per month*.*

I understand that insurance benefits assigned to Dr. Samuel R. Moss must be paid within 45 days from the date of insurance billing. If the insurance company has not paid within 45 days, I agree to pay Dr. Samuel R. Moss the full balance within the credit limits of the office. Any payment received by Dr. Moss after my balance is paid will be refunded to me. I understand that Dr. Moss' office cannot be responsible for collecting my insurance claim or for negotiating a settlement on a disputed claim. I agree to pay all balances not covered by my insurance carrier.

I understand that any minor (17 or under), when brought into Dr. Moss' office for treatment, should have their estimated portion at that time for services rendered.

I agree to give at least 48 hours notice if I need to change my appointment. I agree to pay $25.00 for the appointment time lost if I fail to keep my appointment without giving notice.

I understand that fee estimates quoted are based on all appointments being kept. Fees quoted will remain valid for 90 days.

I understand that if it is necessary for Dr. Samuel R. Moss to retain the services of an attorney to collect my unpaid balance, I will be responsible for all court costs, attorney's fees and any other collection fees which may be incurred as a result of my account being turned over for collection as allowed by the State of Louisiana.

I agree to pay a fee of $25.00 for any check returned N.S.F., Account closed, etc.

I have read and understand the above

____________________________________	____________________
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR	*DATE*

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Release of Photos

I, ________________________________hereby give permission/consent to the use of my pictures and name by Dr. Samuel R. Moss, a professional corporation, its employees and agents for advertising, promotion, educational and related purposes.

Patient's Signature:__________________________ Date:_____________

Patient's name (print)_________________________

Witness Signature:___________________________ Date:_____________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME ____

RELATIONSHIP TO PATIENT ____

SIGNATURE ____

DATE _________________________________

==

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE:_________________INITIALS:________REASON:__________________________________