

Dr. Samuel R. Moss, D.D.S.
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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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: _____