Benoit Family and Cosmetic Dentistry_____

We are committed to excellence in dentistry, and patient service. Thank you for taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need any assistance please ask - we will be happy to help.

ABOUT YOU

Whom may we thank for referring you or how did you find out about our office? _____

Today's Date: _____

Name: _____ I prefer to be called by: _____Male ☐ Female ☐

☐ Single ☐ Married ☐ Child ☐ Other { }Birth Date: _____/_____/_____ S.S. #_____

Home Address: _____City _____ _____State____ Zip_____

Home Phone: (____)_____Work Phone: (____)_____ext.____ Cell (____)_____

Email Address: _____**can we contact you by email or text messaging for confirmation of appt.'s {Y or N}**

Employer: _____How long there? _____ Occupation: _____

Employer's Address: _____City: _____ State: ___ Zip:_____

PERSON RESPONSIBLE FOR ACCOUNT (if other than yourself)

{☐} Same as Above Name: _____Birth Date: _____/_____/_____ Relation: _____

Billing Address: _____City: _____ State:_____ Zip:_____

Home Phone: (____)_____ _____Work: (____)_____ Cell: (____)_____

S.S. #: _____ Employer: _____Occupation: _____

SPOUSE'S INFORMATION (if applicable)

{☐} Same as above Name: _____Birth Date: _____/_____/_____

Employer: _____Work: (____) _____Cell: (____)_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (____)_____ __Group/Policy #:_____

Insured's Name: _____ Insured's Birth Date: _____/_____/_____ Relation:_____

Insured's social security #:_____ Insured's Employer:_____

SECONDARY INSURANCE: PLEASE PRESENT CARD TO FINANCIAL COORDINATOR UPON YOUR VISIT TO THE OFFICE

CONTINUE TO NEXT PAGE

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (____)_____

Do you have or have you ever had any of the following? Please check only the ones that apply:

☐ Allergies/Hay Fever	☐ Diabetes	☐ Heart Surgery *	☐ Rheumatic Fever
☐ Anemia	☐ Epilepsy or Seizures	☐ Hepatitis	☐ Rheumatism
☐ Angina	☐ Excessive Thirst	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Arthritis	☐ Fainting or Dizziness	☐ HIV*/AIDS	☐ Sinus Problems
☐ Artificial Joint, implants *	☐ Fever Blisters/Cold Sores	☐ Kidney Problems	☐ Stroke
☐ Artificial Heart Valves*	☐ Frequent Cough	☐ Liver problems	☐ Surgical Shunt or Stent *
☐ Asthma	☐ Glaucoma	☐ Mental Disorders	☐ Thyroid Problems
☐ Breathing Problems	☐ Heart Disorder (congenital)*	☐ Mitral Valve Prolapse*	☐ Tuberculosis
☐ Cancer	☐ Heart Infection	☐ Osteoporosis	☐ Ulcers
☐ Chemical Dependency	☐ Heart Murmur*	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Heart Pace Maker	☐ Respiratory Problems	☐ Organ Transplant Surgery

This condition may require antibiotic premedication for certain dental procedures

YES NO

☐ ☐ Do you have any health problems that were not listed above or need further clarifications?

If yes, explain: _____

☐ ☐ Are you now under the care of a physician? If yes, explain: _____

☐ ☐ Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, explain: _____

☐ ☐ Are you taking any medications or herbals currently? If yes, please list: _____

_____

☐ ☐ Are you allergic to any medications or substances? If yes, please check boxes and explain further below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Metal of any kind ☐ Latex ☐ Other_____

☐ ☐ Have you or do you use any type of tobacco? If yes, please explain what type _____

☐ ☐ Do you use any of the following or any type of osteoporosis medication:

☐ Fosamax ☐ Boniva ☐ Didronel ☐ Actonel ☐ Actonel with Calcium ☐ Reclast

Women (please check): ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

CONTINUE TO NEXT PAGE

DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health they deserve. This begins with a careful diagnosis and personalized treatment (game) plan. We will perform a **comprehensive oral examination** of your teeth, gums and underlying bone, your jaw joints and bite (the way your teeth meet up). We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs and moulds (impressions) of your teeth to further evaluate areas of concern. Once and if these records are taken, Dr. Benoit will evaluate them and discuss with you your level of oral health and present treatment options. A **personalized treatment (game) plan** will be developed to help you achieve the goals that we set together.

Please help us better understand your dental health needs and goals by answering the following questions (check the best answer):

1- Have you had a complete set of x-rays (pictures of all of your teeth not just the two or four taken on each side) within the last 3 years? ☐ **yes** ☐ **no**

2- I have a ☐ **low** ☐ **moderate** ☐ **high** fear of going to the dentist

3- My mouth and teeth are ☐ **very** ☐ **moderately** ☐ **not** comfortable

4- I am ☐ **very satisfied** ☐ **satisfied** ☐ **dissatisfied** with the appearance of my teeth

5- I think my present state of dental health is ☐ **excellent** ☐ **good** ☐ **fair** ☐ **poor**.

6- I would say that my main concerns with my dental health are: _____

7- I am interested in a smile, bite and TMJ evaluation and personalized treatment plan to enhance my overall dental health and smile.
☐ **Yes** ☐ **No**

8- Please check which statement below best represents the level of dental health you wish to achieve. (it is not uncommon for people to begin at one level and progress to a higher level over time)

☐ **HEALTH LEVEL 1- EMERGENCY CARE**

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

☐ **HEALTH LEVEL 2- MAINTENANCE CARE**

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or financial considerations. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

☐ **HEALTH LEVEL 3- COMPREHENSIVE CARE**

I am interested in comprehensive care to achieve and maintain a higher level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

☐ **HEALTH LEVEL 4- COMPREHENSIVE & COSMETIC CARE**

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic (cosmetic), dental health.

Questions about your Bite and Sleep Patterns

Yes No

- ☐ ☐ 1. Do you have difficulty or pain opening your mouth?
- ☐ ☐ 2. Does your jaw “get stuck”, “lock”, or “go out”?
- ☐ ☐ 3. Do you have difficulty or pain when chewing, talking, or using your jaws?
- ☐ ☐ 4. Are you aware of noises in your jaw?
- ☐ ☐ 5. Do your jaws regularly feel stiff, tight or tired?
- ☐ ☐ 6. Do you have pain in or about the ears, temples or cheeks?
- ☐ ☐ 7. Do you have frequent headaches in the temporal area, neck aches, or toothaches?
- ☐ ☐ 8. Have you had a recent injury to your head, neck or jaw?
- ☐ ☐ 9. Have you been aware of any recent changes in your bite (the way your teeth meet up)?
- ☐ ☐ 10. Have you been previously treated for unexplained facial pain or jaw joint pain?
- ☐ ☐ 11. Do you have any problems chewing bagels, protein bars, or anything chewy?
- ☐ ☐ 12. Do you have problems chewing gum? Does it hurt your jaw or jaw joint?
- ☐ ☐ 13. Have your teeth changed in the last 5 years? (Wear, shorter, thinner, open spaces, looseness)
- ☐ ☐ 14. Do you have more than one bite?
- ☐ ☐ 15. Do you sleep restlessly?
- ☐ ☐ 16. Are you tired when you wake up?
- ☐ ☐ 17. Do you feel like you have not slept after you have slept a full night?

To the best of my knowledge, all of the preceding answers are correct. I also state that I have been given a copy of of all of the office policies. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

My signature acknowledges that:

1) **I understand and will comply with the office APPOINTMENT POLICY**
2) **I understand and will comply with the office FINANCIAL POLICY**
3) **I understand and agree to the GENERAL CONSENT TO TREATMENT**
4) **I authorize the RELEASE OF INFORMATION**
5) **I authorize PHOTOGRAPHS to be taken of me and shown to other patients and for educational programs**
6) **I have received a copy of the office’s NOTICE OF PRIVACY PRACTICES.**

X_____ **Date:** _____

Signature of patient, parent or guardian

From the Office of Brian J. Benoit, D.D.S.

APPOINTMENTS

We value your time, please value ours. Because we recognize the value of your time, you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Also, please make every effort not to change your scheduled appointment. If you find you must change an appointment, please provide us at least **24 hours advanced notification** so that we may use that time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. A **charge up to the full fee of the appointment value** may be applied for a broken or missed appointment without adequate advanced notification. Thank you for your cooperation in this very important matter.

FINANCIAL POLICY

We would like our patients to be informed of our office financial policy. We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our financial policy.

Payment is due in full at the time service is rendered unless a previous arrangement has been made and approved by our financial coordinator. We accept cash, personal checks, Visa, MasterCard, American Express, Discover, and financing is available only through Care Credit based upon approval. Returned checks are subject to a NSF fee of $100.00 per check. If the check is not settled with the financial coordinator, it may be turned over to the Terrebonne Parish District Attorney's office. If accounts become delinquent over 60 days and contact is either denied or not accepted by the patient or patient's guardian, accounts will be turned over to our collection Attorney. Additional fees will be incurred.

If you have dental insurance, you must bring in your dental insurance card for proof of insurance and we will verify benefits in order to submit your insurance claim forms for you. However, you must realize:

1) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2) We cannot render services on the assumption that the charges will be paid for by the insurance company. All charges are your responsibility from the date the services are rendered.

3) Our fees are generally considered to fall within the acceptable range (U.C.R.) by most insurance companies, and therefore should be covered up to the maximum allowance determined by each carrier

4) Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

5) Remember: please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

6) In regards to usual and customary fees; the office of Brian J. Benoit, D.D.S. feels that we provide the highest quality care for our patients. Therefore we feel our fees should reflect this. Usual and customary fees reflect "an average" and we feel that we go above and beyond this with our care and service.

We must emphasize that as dental care providers, our relationship is with you, the patient, and not your insurance company. While filing your insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the

services are rendered. We realize that temporary financial problems may affect timely payment to your account. If such situations do arise, we encourage you to contact our financial coordinator promptly for assistance in the management of your account.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Brian Benoit. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Brian Benoit to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Brian Benoit

Photography Release

I authorize Dr. Brian Benoit to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients and presentations to better explain their treatment options and educational programs.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for <u>treatment</u> purposes are:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of use of your health information for <u>payment</u> purposes: We submit requests for payment to your health insurance company. The health insurance company or business associate helping us to obtain payment, request information from us regarding your medical care given. We will provide information to them about you and the care given.

Example of use of your information for <u>Health Care Operations:</u> We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

<u>YOUR HEALTH INFORMATION RIGHTS</u>

The health and billing records we maintain are the physical property of the doctor's office. You have the following rights with respect to your Protected Health information.

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office – we are not required to grant the request, but we will comply with any request granted;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
3. Right to inspect and copy your health record and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; appeal a denial of access to your protected health information except in certain circumstances;
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request; and,

If you want to exercise any of the above rights, please contact the office manager of our office at 985-868-4681 or 306 Civic Center Blvd, Houma, LA 70360 in person, or in writing, during normal business hours. We will provide you with assistance on the steps to take to exercise your rights.

OUR RESPONSIBILITIES

The office is required to:

1. Maintain the privacy of your health information as required by law;
2. Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
3. Abide by the terms of this Notice;
4. Notify you if we cannot accommodate a requested restriction or request;
5. Accommodate your reasonable requests regarding methods to communicate health information with you;
6. Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the office at 985-868-4681 during normal business hours.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Office Manager. You may also file a complaint by mailing it to the Secretary of Health and Human Services whose street address is 1301 Young Street Suite 1169, Dallas, TX 75202, 214-767-4056.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services. Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule.

PATIENT CONTACT

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

OTHER DISCLOSURES AND USES

Notification- Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death**.**

Child Abuse & Neglect- We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.

Food and Drug Administration (FDA) – We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Victims of Abuse, Neglect, or Domestic Violence- We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.

Oversight Agencies- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations; inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.

Judicial/Administrative Proceedings – We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.

Law Enforcement – We may disclose your protected health information for law enforcement purposes as required by law; such as when required by court order, including laws that require reporting of certain types of wounds or the physical injury.

Research – We may disclose information to researchers, when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved their research.

Threat to Health and Safety – To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Communications with Family – Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. We may use and disclose your protected health information to assist in disaster relief efforts.

Workers Compensation- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health- As required by law, we may disclose your public health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institutions- If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, our protected health information necessary for the health and safety of other individuals

Photos, Study Models, and X-rays- We may use photos, study models, and x-rays for the purpose of education, publication, or advertising unless you object.

Other Uses and Disclosures – Other uses and disclosures besides those identified in the Notice will be made only as otherwise authorized by law or with your written authorization, which you may revoke except to the extent information or action has already been taken.

Website- If we maintain a website that provides information about our entity, this Notice will be on our website.