Benoit Family and Cosmetic Dentistry and Treatment of TMJ Disorders

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

Who may we thank for referring you to our office or how did you find out about our office: ___________________________

Name: _______________________________ **I prefer to be called by:** _____________________ **Male ( ) Female ( )**

( ) Single ( ) Married ( ) Child ( ) Other Date of Birth: ______________________________ **SS #:** __________________

Home Address: _____________________________________ **City:** ________________________ **State & Zip:** ________________

Home Phone: _______________________ **Work Phone:** _________________________ **Cell Phone:** __________________________

Email Address: ____ **Can we contact you by email or cell for appointments? Y N**

Employer: ____ **How long there?** ___________ **Occupation:** ____________

Employer's Address: ____ **City:** ________________________ **State & Zip:** ____________

PERSON RESPONSIBLE FOR ACCOUNT (if other than yourself)

( ) Same as above If different please fill out the following

Name: _____________________________________ **Date of Birth:** ________________ **Relation to patient:** __________________

Billing Address: ____ **City:** _______________________ **State & Zip:** _____________

Home Phone: __________________________ **Work Phone:** __________________________ **Cell Phone:** _____________________

SS #: ___________________________________ **Employer:** ___________________________ **Occupation:** _____________________

SPOUSE INFORMATION (EMERGENCY CONTACT INFORMATION IF NOT MARRIED)

Name: __________________________________ **Date of Birth:** ____________________ **Employer:** ____________________________

Work Phone: ___________________________ **Home Phone:** _____________________ **Cell Phone:** __________________________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance (please have card ready to give to financial coordinator)

Insurance Company's Name: ______________________ **Phone Number:** _____________________ **Group Policy #:** __________

Insured's Name: ________________________________ **Insured's Date of Birth:** ______________ **Relation to Patient:** _______

Insured's SS #: _________________________ **Insured's Employer:** ____

SECONDARY DENTAL INSURANCE: PLEASE PRESENT CARD TO FINANCIAL COORDINATOR UPON YOUR VISIT TO OUR OFFICE.

PLEASE CONTINUE TO NEXT PAGE

Please Initial ___________________

MEDICAL HISTORY INFORMATION

Name of your primary care physician: ____
Do you have or ever had any of the following? Please check on the ones that apply.

( ) allergies/hay fever	( ) diabetes	( ) heart surgery*	( ) rheumatic fever
( ) anemia	( ) epilepsy or seizures	( ) hepatitis	( ) rheumatism
( ) arthritis	( ) Excessive thirst	( ) High Blood Pressure	( ) sickle cell disease
( ) Artificial Joints, implants*	( ) Fever Blisters/cold sores	( ) Kidney Problems	( ) stroke
( ) Angina	( ) Fainting or Dizziness	( ) HIV/AIDS	( ) Sinus problems
( ) 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	( ) Organ Transplant Surgery	( ) Sleep Apnea

***this condition may require you to take antibiotics before dental appointments**

Yes No Do you have any other health problems that were not listed above?

If yes, please explain? ____

Yes No Are you now under the care of a physician? If yes, please explain? ____________________________________

____

Yes No Have you been admitted to a hospital or need emergency care during the past two years? ______________

____

Yes No Are you taking any medications or herbal supplements (prescription or over the counter)? _____________

____

Yes No Are you allergic to any medications or substances (like latex)? Please list: _____________________________

____

Yes No Have you or do you use any type of tobacco product, and if you smoke, how many packs per day and

explain:____

Yes No Do you use any type of osteoporosis/osteopenia medications? If so, please list: ________________________

Women: Are you pregnant: Y N Trying to get pregnant: Y N Nursing: Y N

PLEASE CONTINUE TO NEXT PAGE

Please initial _______________________

DENTAL HEALTH

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 in the last three years (this is a set of approx. 22 x-rays) Y ( ) N ( )**
2) **I have a low ( ), moderate ( ), or high ( ) fear of going to the dentist**
3) **My mouth and teeth are highly ( ), moderately ( ) not comfortable.**
4) **I am satisfied ( ) or 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 concern with my dental health is (are): ____**

____

QUESTIONS FOR TMJ, BITE AND SLEEP CONCERNS

Yes	No	
( )	( )	Do you have difficulty or pain opening your mouth?
( )	( )	Does your jaw get stuck or locked or goes out?
( )	( )	Do you have difficulty or pain when chewing or talking?
( )	( )	Are you aware of any popping, clicking or noises in your jaw joints?
( )	( )	Do your jaw joints feel stiff, tight or tired?
( )	( )	Do you have any pain in or around the ears, temples, or cheeks?
( )	( )	Do you have frequent headaches in the temporal area
( )	( )	Do you have a history of neck problems (whiplash injuries)?
( )	( )	Have you had any injuries to your head, neck, jaw, or chin area?
( )	( )	Are you aware of any recent changes in your bite (shorter, worn, loose)?
( )	( )	Have you been previously treated for bite, tmj or facial pain issues?
( )	( )	Do you have any problems eating or chewing bagels, power bars or anything with substance?
( )	( )	Do you have problems when you chew gum?
( )	( )	Are you aware of any clenching or grinding issues at night or during the day?
( )	( )	Do you have arthritis?
( )	( )	Do you fell rested when you wake up in the morning?
( )	( )	Do you have any problems falling asleep?
( )	( )	Do you have any problems staying asleep?

CONTINUE TO THE NEXT PAGE

Please initial ____________________

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 the 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 we have a financing option through Care Credit based on approval. Returned checks will be charged an NSF fee of $100.00. If the check is not settled with our office, it will 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 attorney for collection. 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 are not in network with any insurance companies. You as a patient can go to any dentist of your choice by law. We will still file your paperwork with your insurance company as a courtesy to you.**
3) **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 of services are rendered.**
4) **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.**
5) **Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.**
6) **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**
7) **In regard 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 realize temporary financial problems may affect timely payments 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.

APPOINTMENTS

We value your time, please value ours also. 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 with at least 48 hours advance 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 for the appointment value may be applied for a broken or missed appointment without adequate notification. We also ask that in order to schedule an appointment on Dr. Benoit's schedule that you place a deposit down to reserve this appointment.

CONTINUE TO THE NEXT PAGE

Please initial ___________________

APPOINTMENT CANCELLATION POLICY

First of all, I would like to thank you for choosing Benoit Family and Cosmetic Dentistry and Treatment of TMJ disorders. Over time, we have encountered last minute cancellations and patients who don't show up. We ask you to please keep in mind, that when we make you an appointment, we are reserving a treatment room for you and only you to serve your individual needs. We value our patient's and realize that your time is important. In return, we are asking for the same courtesy. That is why we are asking that if you must cancel or reschedule an appointment to **PLEASE give us 48 hour's notice.** This courtesy makes it possible to give your reserved room and time to another patient. Therefore, effective immediately:

> **There will be a $50.00 charge for not showing up or rescheduling a hygiene/checkup 48 hours prior to your appointment. Also, for patients having any appointments for work done on Dr. Benoit's schedule, the same will apply only the fee will depend upon the deposit made at the time of scheduling. Repeated cancellations or missed appointments will result in requiring a credit card to reserve future appointments.**

We thank you in advance for understanding and once again thank you for choosing Benoit Family Dentistry. If you have any questions, please call the office at the following number (985)868-4681.

CREDIT CARD POLICY

Benoit Family and Cosmetic Dentistry has implemented a credit card policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance has paid their portion and notified us of the amount that is your share. At that time, any remaining balance owed by you that is $500.00 or less will be charged to your credit card and a copy of your charges on a receipt will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generated and send out. The combination will benefit everybody in helping to keep the cost of health care down.

There in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, coinsurance, and deductibles will still be due at the time of service. If you have any questions about this payment method, do not hesitate to ask.

I AUTHORIZE BENOIT AND FAMILY COSMETIC DENTISTRY AND TREATMENT OF TMJ DISORDERS TO CHARGE ANY OUTSTANDING BALANCES ON MY ACCOUNT TO THE FOLLOWING CREDIT CARD OR DEBIT CARD.
VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER (PLEASE CIRCLE ONE)

DEBIT OR CREDIT CARD? (PLEASE CIRCLE ONE)

ACCOUNT #:____

EXPIRATION DATE: ____

CODE ON THE FRONT OR BACK OF CARD: ______________________________

NAME ON CARD (PLEASE PRINT): ______________________________

BILLING ADDRESS: ____

SIGNATURE: ______________________________ DATE: ____________________

CONTINUE TO THE NEXT PAGE

Please initial ____________

AUTHORIZATION AND CONSENT

General consent of for treatment

1) **I agree to a dental examination by Dr. Brian Benoit. I understand that additional diagnostic procedures and dental treatment 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

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

Assignment of benefits

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

Photography Release

1) **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 options and educational programs.**

My signature acknowledges that:

1) **I understand and will comply with the office APPOINTMENT POLICY** **please initial ____________**

2) **I understand and will comply with the office FINANCIAL POLICY** **please initial ____________**

3) **I understand and will comply with the GENERAL CONSENT OF TREATMENT** **please initial ____________**

4) **I authorize the RELEASE OF INFORMATION** **please initial ____________**

5) **I authorize PHOTOGRAPHS to be taken of me an shown to other patients and for educational programs**

   please initial ____________

6) **I have received a copy of the office's NOTICE OF PRIVACY PRACTICES.** **please initial ____________**

7) **I understand and will comply with the office APPOINTMENT CANCELLATION POLICY.**

   please initial ____________

8) **I understand and will comply with the office CREDIT CARD POLICY.** **please initial ____________**

9) **I understand that Dr. Benoit is NOT IN NETWORK WITH ANY INSURNACE COMPANY but will file your insurance as a convenience. Per Louisiana law, you can still go to any Dentist you choose.**

   please initial ____________

X ____ Today's Date: __________________________

Signature of patient, parent, or guardian