ALLISON MELANCON, DDS

Your home for amazing dental care

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor Drivers License # _____

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # ( ) _____ Cell Phone # ( ) _____ Email _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone ( ) _____

RESPONSIBLE PARTY (Parent or Guardian)

Name of Person

Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone ( ) _____

Birthdate _____ Currently a patient in our office? ☐ Yes ☐ No

Employer _____ Work Phone ( ) _____

E-Mail _____ Cell Phone ( ) _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

19317 N. 10th Street, Suite E. Covington, La 70433

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Check (✓) if you have or have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collecting between the teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____ Are you happy with your smile? _____

Would you like more information about: ☐ **Botox** ☐ **Juvederm** ☐ **Invisalign**

MEDICAL HISTORY

Have you ever had any serious illnesses or operations?? ☐Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✓) if you have or have had problems with any of the following:

☐ Acid Reflux	☐ Congenital Heart lesions	☐ Hepititis / Herpes	☐ Scarlet Fever / Shingles
☐ Anemia	☐ Cortisone Treatments	☐ Hernia Repair	☐ Shortness of Breath
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Skin Rash
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Stroke
☐ Artificial Joints, Pins, etc.	☐ Diabetes	☐ Jaw Pain	☐ Swelling of Feet or Ankles
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Bleeding Abnormally	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Blood Disease	☐ Headaches	☐ Pacemaker / Heart Surgery	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcer
☐ Chemical Dependency	☐ Heart Problems	☐ Radiation Treatment	☐ Venereal Disease
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Disease	☐ History of substance abuse
☐ Circulatory Problems	☐ Surgical Implant	☐ Rheumatic fever	How long in recovery? _____

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

☐ Aspirin	☐ Local Anesthetic	☐ Iodine	☐ Metal / Chemicals
☐ Barbiturates (Sleeping Pills)	☐ Penicillin	☐ Latex	☐ Other _____
☐ Codeine	☐ Sulfa	☐ None	_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed aooropriate by Doctor to make thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between and the insurance carrier, and not between the insurance carrier and the Doctor and that i am still fully responsible for all dental fees. I also assign all insurance benefits to the Doctor. Any payments recieved by the Doctor from my insuracne coverage will be credited to my account.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosed with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = (your weight in pounds X 703)

_____

(your height in inches X your height in inches)

Sleep, Breathing & Habit Questionnaire — Children & Adolescents

Full Name:	Age:	Date:

Please indicate if your child experiences or has experienced any of these symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence 1 - Occurs Rarely 2 - Occurs 2 to 4 times per week 3 - Occurs 5 to 7 times per week

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bed wetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Seasonal allergies
18. _____ Ear infections of history of ear infections
19. _____ Short attention span
20. _____ Trouble focusing
21. _____ Difficulty listening/ often interrupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory Issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech issues*
28. _____ Avoidance behavior towards food or certain types of food

***Speech Questionnaire -** to be filled out only if #27 was indicated above

Please check all that apply

_____ Is it difficult to understand your child's speech?

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Other have difficulty understanding speech?

_____ Gets frustrated when people can't understand speech?

_____ Speech sounds abnormal?

_____ Sometimes omits consonants?

_____ Uses M, N, NG instead of P, V, S, Z sounds?

_____ Liquids and/or solids get into nasal area when eating or drinking?

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DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to treatment.

General:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

*Signature*_____ *Date* _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. In refusing, you understand that Allison Melancon Family Dentistry *may not be permitted* to process your insurance claims or communicate with other critical parties related to your care.
I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____

Signature *Please print your name here* *Date*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

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No Show/Cancellation Policy

One of the great things about our office is that when you schedule your appointment, we hold that time specifically for you! We also prepare ahead of time for your appointment, making sure that we are staffed accordingly and that materials for your appointment are ordered and ready for you.
Our office must charge a fee of $60.00/hour of scheduled time (ex: 1.5 hours equals $90) to your account for all "no-shows" or cancellations in which the patient does not give the following timely notice:
*24-hour notice for cleaning appointments with our hygienist.
* 48-hour notice for treatment appointments with Dr. Melancon for appointments under 60 minutes.
* 72-hour notice for appointments over 60 minutes.
We generally provide a complimentary text reminder prior to your appointment. However, it is YOUR responsibility to remember your appointment time/date and/or to call the office to confirm. Text cancellations are not permitted since we do not receive texts in real time. If it is after or before regular business hours, please leave a message.
I have read and understand/ comply with the above policy:
Patient Signature
:_____Date_____
Patient Printed Name:
_____

Insurance Policy

As a courtesy to you, our patient, this office will ask for an insurance benefits summary from your insurance company and file dental claims. However, we do not accept responsibility for communication or collections from your Insurance Company. As the patient, you should also verify coverage for your benefits and should be aware of any limitations, waiting periods, or exclusions on your policy.It is also your responsibility to ask our office to send a predetermination for your services since pre-authorizations are not done routinely.
We receive a summary of benefits from your insurance company, which is usually an abridged version of your policy. We use this summary of benefits to provide an ESTIMATE for your treatment. Estimates for treatment are just that, estimates. It is your responsibility to communicate with your Insurance Company on a regular basis regarding payment of outstanding claims as needed. If we do not receive payment from your Insurance Company within 60 days from time of service, you may be required to pay any outstanding balance in full. Please understand that insurance breakdowns, pre-authorizations, and treatment estimates are not a guarantee of payment by our office or your insurance company. All fees are the responsibility of the patient. The Insurance Contract is made between you, the patient, and your Insurance Company. Not our office. The ultimate obligation for payment is with you, the patient.
I have read and understand/ comply with the above policy:

Patient Signature_____ Date: _____

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient's Name:_____ Date of Birth: _____

I request and authorize _____ to release dental information of the patient named above to:

Name: Allison Melancon, D.D.S

Email X-Rays to: allisonmelancondds@gmail.com

Address: 19317 North 10th. Street Suite E. Covington, La 70433

This request and authorization applies to:

□All dental information including all x-rays & chart notes ect.

Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herp simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. results, HIV/AIDS testing, whether negative or Positive, to the person(s) listed above. I understand that the person(s) listed above Will be notified that I must give specific written permission before disclosure of these Test results to anyone.

*All patients 18 years old and older must sign their own release unless a power of attorney or guardianship is in place.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Name Of Person Signing The Release (Please Print): _____

Relationship To Patient (Please Circle One):

Legal Guardian(Other Than Parent) Patient(Self) Power Of Attorney

Patient/Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED