Dr. Lawrence N. Frost, III D.D.S.
General & Family Dentistry

525 Metairie Road • Metairie, LA 70005
(504) 833-2500 • Fax (504) 833-7080

## PATIENT INFORMATION

NAME _____ (LAST / FIRST / M.I.) SEX _____ DATE OF BIRTH _____ AGE _____

NICKNAME _____ S.S. # _____ MARITAL STATUS _____

ADDRESS _____ (STREET / CITY / STATE / ZIP)

TELEPHONE _____ (HOME) _____ (WORK) EXT.# _____ _____ (BEEPER OR CELL PHONE)

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? ☐ YES ☐ NO IF YES, PLEASE GIVE NAME _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

## RESPONSIBLE PARTY INFORMATION

NAME _____ (LAST / FIRST / M.I.)

ADDRESS _____ (STREET / CITY / STATE / ZIP)

TELEPHONE _____ (HOME) _____ (WORK) EXT.# _____ _____ (BEEPER OR CELL PHONE) RELATIONSHIP TO PATIENT _____

S.S. # _____ DRIVER'S LICENSE # _____ DATE OF BIRTH _____ OCCUPATION _____

EMPLOYER _____ ADDRESS _____

## FAMILY INFORMATION

SPOUSE / PARENT'S NAME _____ (LAST / FIRST / M.I.)

EMPLOYER _____ WORK # _____

S.S. # _____ DRIVER'S LICENSE # _____

DATE OF BIRTH _____ HOME # _____

## EMERGENCY CONTACT INFORMATION

NAME _____

ADDRESS _____

TELEPHONE _____ RELATIONSHIP _____

## DENTAL INSURANCE INFORMATION

INSURED'S NAME _____

INSURANCE CO. (PRIMARY) _____

INSURANCE CO. (SECONDARY) _____

INSURED'S EMPLOYER _____

INSURED'S ID # OR S.S. # _____ DATE OF BIRTH _____

GROUP # _____ TELEPHONE _____

Your dental insurance is your responsibility BUT WE CAN HELP... Regardless of what we might calculate as your benefits in dollars, we must stress the fact that you, the patient, are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefits from most insurance companies. This will reduce your immediate out of pocket expenditures. Any estimate is based on limited information obtained from your insurance company. We do not have a contract with your insurance company only you do. We are not responsible for how your insurance company pays its claims. We allow 45 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

## METHOD OF PAYMENT

☐ CASH ☐ CHECK ☐ DEBIT CARD ☐ CREDIT CARD

WE DO NO BILLING. All balances must be paid in full at the time of service. By signing as responsible party below, you are stating that you understand that any balance left after insurance payments must be paid within 30 days. Failure to pay the balance in 30 days will result in an $8.00 monthly billing charge. In the case of default of payment, you promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

## AUTHORIZATION

I hereby authorize payment directly to DR. LAWRENCE N. FROST, III of insurance benefits otherwise payable to me. I understand that I am personally responsible for all costs of dental treatment. I hereby request and authorize DR. LAWRENCE N. FROST, III to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history (on the next or separate page provided) are true and correct to the best of my knowledge. If I have any changes in my health, I will inform my dentist.

I am in a legal position to agree to the authorization above and claim responsibility for this patient as well as the payment for all treatment.

X _____ DATE _____

☐ ADULT PATIENT ☐ PARENT ☐ GUARDIAN ☐ OTHER (SPECIFY)

(OVER)

# HEALTH HISTORY

(Confidential)

## DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe _____ YES NO

When was your last dental visit or X-rays? _____

Have you ever had a bad experience in a dental office? Describe _____ YES NO

Are you interested in using nitrous oxide or I.V. sedation for your dental appointments? _____ YES NO

Do your gums ever bleed? Discuss _____ YES NO

Do you want to keep your remaining teeth? ..... YES NO

Are you interested in whitening your teeth? ..... YES NO

Are you happy with your smile? ..... YES NO

Do you have bad breath? ..... YES NO

Name of previous dentist? _____

How often do you floss? _____ How often do you brush? _____

## MEDICAL HISTORY

Medical doctor's name _____ Phone Number _____

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why? _____ YES NO

(Women) Are you pregnant? ..... YES NO

Nursing? ..... YES NO

Taking birth control pills? ..... YES NO

Have you ever been treated or diagnosed with any of the following? **CIRCLE** yes or no next to EACH one.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS / HIV ..... | YES | NO | Glaucoma ..... | YES | NO | Liver Disease ..... | YES | NO | Stomach Problems ..... | YES | NO |
| Anemia ..... | YES | NO | Hay Fever ..... | YES | NO | Mitral Valve Prolapse .... | YES | NO | Stroke ..... | YES | NO |
| Arthritis ..... | YES | NO | Head Injuries ..... | YES | NO | Mental Disorders ..... | YES | NO | Thyroid Disorders ..... | YES | NO |
| Artificial Joints / Valves .. | YES | NO | Heart Disease ..... | YES | NO | Nervous Disorders ..... | YES | NO | Tuberculosis ..... | YES | NO |
| Asthma ..... | YES | NO | Heart Murmur ..... | YES | NO | Pacemaker ..... | YES | NO | Tumors ..... | YES | NO |
| Blood Disease ..... | YES | NO | Hemophilia ..... | YES | NO | Psychiatric Problems .... | YES | NO | Ulcers / Colitis ..... | YES | NO |
| Cancer ..... | YES | NO | Hepatitis A B or C ..... | YES | NO | Radiation Treatment ..... | YES | NO | Venereal Disease ..... | YES | NO |
| Diabetes ..... | YES | NO | Herpes ..... | YES | NO | Respiratory Problems .... | YES | NO | | | |
| Dizziness ..... | YES | NO | High Blood Pressure .... | YES | NO | Rheumatic Fever ..... | YES | NO | Do you have a tobacco habit? | | |
| Epilepsy ..... | YES | NO | Jaundice ..... | YES | NO | Rheumatism ..... | YES | NO | | YES | NO |
| Fainting ..... | YES | NO | Jaw Problems ..... | YES | NO | Scarlet Fever ..... | YES | NO | | | |
| Fever Blisters ..... | YES | NO | Kidney Disease ..... | YES | NO | Sinus Problems ..... | YES | NO | Are you pregnant? | YES | NO |

## MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone Number _____

## ALLERGIES

Are you allergic to:

| | | | | | |
|---|---|---|---|---|---|
| Aspirin ..... | YES | NO | Penicillin ..... | YES | NO |
| Codeine ..... | YES | NO | Sulfa ..... | YES | NO |
| Latex ..... | YES | NO | Other _____ | | |
| Local Anesthetic ..... | YES | NO | _____ | | |

## SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form. (Strictly Confidential)

Date _____ Signature _____