



Turn left off of Hwy 22 at the light by Walgreens (Dalwill Drive). Go to the end of Dalwill until it reaches the West Approach (Regions Bank will be on the right).

When you get to the approach, turn right onto the West Approach going towards Hwy 22. Get into the left lane. When you get to the light at Hwy 22, there will be a left turn lane. Turn onto the service road. You will be facing Goodyear Tire. Turn left and come to the end of that road. We are next to the restaurant *Shuck and Jive*. Drive along side the restaurant, our parking lot is behind our building and the entry way is in the back of the building.

If you need help, do not hesitate to call for further instructions.

Robin
985-626-4447



645 B Lotus Drive North
 Mandeville, LA 70471
 985.626.4447 • www.ident.ws/fotofordental

Chart #: _____
 FOR OFFICE USE ONLY

DENTAL HISTORY

Name _____ Birthdate _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____ Fax _____

How often do you have dental examinations? _____

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

What other dental aids do you use? (waterpik, electric toothbrush, etc.) _____

Are there any areas of your mouth difficult to clean? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Sweets, Hot or cold? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Notice excessive wear on your teeth? Yes No

Hold foreign objects with your teeth?

(Pencils, pipe, pins, nails, fingernails) Yes No

Have frequent dry mouth? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke/Chew tobacco or use other tobacco products? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Gum treatment? Yes No

Your bite adjusted? Yes No

A bite plate, splint, or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Have you ever experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of mouth? Yes No

Headaches, neckaches or shoulder aches?

Sore muscles (neck, shoulders)? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Would you like to improve the appearance of your teeth/smile? Yes No

Does your diet include:

Soft drinks Yes No

amount per day _____

Frequent mints, candies or gum Yes No

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: _____

APPOINTMENTS

Because we recognize the value of your time, you can expect us to see you at the appointed times, so as to keep your time spent in our office as short as possible. Likewise, when you make an appointment with us, we have reserved our times just for you and ask that you be on time. If you cannot keep your appointment, we ask you to give us **at least 48 hours notice** so that we can give your time slot to another patient. Otherwise, our office policy is to charge an hourly rate to help defer some of the overhead expense associated with not having a patient scheduled in your time slot. We believe very strongly that mutual trust and respect for each other's time will strengthen our relationship.

FINANCIAL POLICY

- Unless another financial option is pre-arranged, payment in full is due the day of treatment.
- For procedures requiring long appointment times, 1/3 of the payment is expected to reserve the appointment time.

PAYMENT OPTIONS

1. For your convenience we accept Cash, Check, Visa, MC and Discover.
2. A 5% discount is offered for any treatment plan paid in full at the time the appointment is made.
3. We also offer short and long-term financing through Health Care Credit and Wells Fargo.

FOR PATIENT WITH DENTAL INSURANCE

- As a courtesy, we will accept assignment of your insurance benefits provided we are able to verify current coverage and have received a copy of your insurance card or a signed, completed dental insurance form.
- We will estimate your insurance benefits and will expect your portion of the fee to be paid at each visit. You are responsible for any portion your insurance company does not cover. If for any reason your insurance company pays less than what was estimated, you will be responsible for the unpaid balance.
- If the balance is not paid within 30 days of the billing date, a finance charge of 1.5% per month will be added to the account. In case of default of payment, you will be responsible for any interest on the balance due, together with any collection costs and reasonable attorney's fees incurred in the collection of this account.

AUTHORIZATION AND CONSENT

GENERAL CONSENT TO TREATMENT

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

RELEASE OF INFORMATION

I authorize Dr. Foto 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. Foto.

PHOTOGRAPHY RELEASE

I authorize Dr. Foto 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 to better explain their treatment options (as you may be shown photographs for the same reason).

My signature acknowledges that:

I understand the office policy with keeping Appointments.

I understand and will comply with the office Financial Policy.

I understand and agree to the General Consent to Treatment.

I authorize the Release of Information.

I assign my insurance benefits to Dr. Foto.

Photographs taken of me may be shown to other patients.

I have received a copy of this office's Notice of Privacy Practices.

X _____ Date _____
Signature of Patient, Parent or Guardian