Welcome to our Office! Thank you for choosing us! Today's Date:_____

In order to serve you properly we will gather the following information. **Please Print.** All information is kept confidential.

Patient's Legal Name: **Name you prefer to be called:**	Birthdate:	**Marital Status:** Single ☐ Widowed ☐ Married ☐ Divorced ☐	**We want to address you properly**: Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms. ☐ Rev ☐
Street Address: Mailing Address:	City	State	Zip
Best number where we can reach you during the day:	Business Phone:	Cell Phone:	**Email address: May we use this to contact you regarding your appointments?** ☐ Yes ☐ No
Social Security #:	Driver's License: (Please provide to Receptionist to make a copy for your file)	Employer Name:	Occupation:
Spouse's Name:	Spouse's Birthdate:	Spouse's Social Security #:	
Spouse's Employer:	Spouse's Occupation:	Spouse's Business Phone:	Spouse's Cell Phone:
Do you have **Dental Insurance**? ☐ Yes ☐ No If yes, please hand your Dental card to the Receptionist to make a copy for your file.	If yes, is it through your employer, your spouse's employer or parent's employer? ☐ My Employer ☐ My Spouse's Employer ☐ My Mom's / Dad's Employer		
Nearest friend or relative not living with you?	Relationship to patient	Phone Number	
Who may we thank for referring you to us?	Address		

_____ _____

PATIENT SIGNATURE DATE

MEDICAL HISTORY

Today's Date: _____

Patient Name:_____**Birthdate:**_____

Have you been under the care of a medical doctor during the past 2 years?		Yes	No
If yes, for what?			
Physician's Name:	City:	Phone:	
When was your last medical doctor visit?			
Have you taken any medication or drugs during the past 2 years? **If yes what?**		Yes	No
Have you ever been treated for cancer?		Yes	No
Have you ever been treated for osteoporosis?		Yes	No
Have you ever had intravenous treatment for cancer or osteoporosis?		Yes	No
Are you taking **any** medication, drugs or pills now?		Yes	No
If yes, please list name and dosage:			
Are you aware of having an allergic (or adverse) reaction to any medication or substance?		Yes	No
If yes, please list:			
Have you been a patient in the hospital during the past 5 years? **If yes, for what?**		Yes	No

Indicate which of the following you have had, or have at present:
Circle "yes" or "no" to each item:

Heart Surgery? **If yes, when?**	Yes	No		Asthma – **If yes, when was last attack?**	Yes	No
Heart Disease	Yes	No		Emphysema	Yes	No
Heart Attack? **If yes, when?**	Yes	No		Psychiatric / Psychological Care	Yes	No
Heart Stint / Shunt? **If yes, which?**	Yes	No		Neurological Disorders	Yes	No
Angina (Chest Pain)	Yes	No		Epilepsy or Seizures	Yes	No
Congenital Heart Disease	Yes	No		Allergies or Hives	Yes	No
Repaired?	Yes	No		Tuberculosis Disease	Yes	No
Heart Murmur	Yes	No		Nervous or Anxious	Yes	No
Mitral Valve Prolapse	Yes	No		Arthritis / Rheumatism	Yes	No
Artificial Heart Valve	Yes	No		Artificial Joints (hip, knee, etc)	Yes	No
If yes, When & What placed?				If yes, When, What, & Who did the surgery		
Heart Transplant	Yes	No		Cold Sores/Fever Blisters/Mouth Ulcers (frequent)	Yes	No
Heart Pacemaker	Yes	No		Fainting or Dizzy Spells	Yes	No
Rheumatic Heart Disease	Yes	No		Thyroid Problems	Yes	No
Rheumatic Fever	Yes	No		Sexually Transmitted Disease	Yes	No
Congestive Heart Failure	Yes	No		Hepatitis A B C **If yes, which?**	Yes	No
Infective Endocarditis	Yes	No		A.I.D.S.	Yes	No
Stroke	Yes	No		H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No		Sickle Cell Disease	Yes	No
Latex Sensitivity	Yes	No		Blood Transfusion	Yes	No
Kidney Problems	Yes	No		Yellow Jaundice	Yes	No
If yes, are you on dialysis?	Yes	No		Hemophilia	Yes	No
Bruise Easily	Yes	No		Anemia	Yes	No
If yes, do you take aspirin daily?	Yes	No		Liver Disease	Yes	No
Swollen Ankles	Yes	No		Radiation / Chemotherapy **If yes, which:**	Yes	No
Diabetes – **If yes, what type?**	Yes	No		Tumors	Yes	No
Glaucoma	Yes	No		Alcohol Intolerant	Yes	No
Do you experience frequent bad breath?	Yes	No		Do you use a C–Pap or any other sleep apnea device?	Yes	No
Do your gums bleed?	Yes	No		Do you have frequent headaches? **If yes, how many times per week?**	Yes	No
Do you use tobacco products	Yes	No		Are you aware of clenching or grinding your teeth?	Yes	No
Do you use 2 or more pillows to sleep?	Yes	No		Do you have sensitive teeth?	Yes	No

Do you have or have you had any disease, condition, or problem not listed? What?	Yes	No
Are you satisfied with the appearance of your teeth?	Yes	No
WOMEN: Are you pregnant? _____ **Months** _____ **Nursing?**	Yes	No
WOMEN: **Taking birth control pills or injections?**	Yes	No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

_____ _____

Patient or Legal Guardian Signature **Date**

John T. Mahoney, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Patient Name(please print)_____ Patient's Date of Birth_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed: (please ✓ all that apply)

- ☐ Dental Appointments (times/dates)
- ☐ Financial options / records/information
- ☐ Other (specific)
- ☐ Insurance information
- ☐ Medical /Dental specific information

_____

I authorize the following person(s) to receive this patient information: (please print)

1. _____ DOB_____
2. _____ DOB_____
3. _____ DOB_____

Method of Contact:

With regards to the office contacting, you, the patient at the following may we:

Home – leave a message on your answering machine or with a person answering the phone?	Yes	No
Work– leave a message for you to return our call?	Yes	No
Cell – leave a detailed message on Voice Mail Yes No or send a text?	Yes	No
Email– Send you a detailed message with dental information or an appointment?	Yes	No

What is your email address? _____

Which is your preference for contacting you? Home ___ Work____ Cell Voice_____ Cell Text _____ Email_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at officemanager@johntmahoneydds.com. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires only upon written request of the named patient.

Signature of Patient or Patient's Personal Representative:

_____ _____
Date

If Personal Representative:

Print Name: _____

Signature: _____

Relationship to Patient:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Copy of Signed authorization provided to the individual:

Date:_____

Initials:_____

John T. Mahoney DDS

Family Dentistry
2117 Old Jeanerette Road
Phone or Text (337) 365-5865
Fax (337) 365-6137
Email: frontoffice@johntmahoneydds.com

Dear New Patient:

We are pleased to welcome you to our practice. Please allow us a few moments to familiarize you with some of our office procedures.

Scheduling:

For your convenience our office hours are by appointment only from 7:00 am – 12:00 pm and from 1:00 pm – 4:00 pm. Monday through Thursday.

Should you have a dental emergency, we do have an answering service who takes our calls after hours and on weekends.

We strive to schedule appointments that are convenient for you. Since we try to accommodate so many busy schedules, it can become a very difficult task. Therefore, we must request that if you are unable to keep your scheduled appointment with us, that you kindly give at least a 24 hour notice of change or a charge may be considered.

We have a fully trained and professional team who is eager to help you. ***Dr. John Mahoney*** *is the owner and main dentist of the practice and graduated from LSU School of Dentistry as a General Dentist in May 1985.*

Our team also includes three licensed and registered dental hygienists. **Samantha Stansbury** has been with us since she began practicing in 1998. **Michelle Dupre** began her journey with us in March 2018, although she has been in practice since 2004 and Amy Koethe started February 2019. She graduated from the University of Louisiana @ Monroe and has been practicing since May of 2016.

All of our Registered Dental Hygienists are CPR certified, and licensed in the administration of anesthesia.

Our team strives for excellence in all areas of dentistry. We are always learning new ways to serve our patients. Our practice philosophy has always been and will always be to treat our patients the way we desire to be treated.

Dental Insurance: *For your convenience, we do accept assignment for and file for many dental insurances. We charge you an* ***estimated*** *out of pocket. This estimated amount cannot be considered as a definite amount due until your insurance carrier actually pays the insurance claims. We must stress that this is a courtesy and that the relationship of insurance is between you and your insurance carrier and we are merely attempting to assist our patients with the cost of their dental treatment. If the dental insurance company does not pay all of the estimated portion within 60 days, the remaining balance becomes due and payable by you, the patient.*

General Consent For Dental Treatment

State Law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand and we are ready to answer any of your questions or explain anything.

Any alternatives to the recommended treatment, including no treatment, have been explained to me.

Furthermore, I give Dr. Mahoney and any member of his team my permission to voice record, tape digitally, videotape and/or take 35mm and/or digital photos of me or my procedure for the purposes of completing my medical record and/or for patient education.

There are risks associated with any dental treatment. This includes the administrations of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre–medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to the following:

Infection	Slough (unanticipated loss of hard and/or soft tissue)
Bleeding	Injury to adjacent structures
Failure of wound to heal	Instrument breakage
Injuries to adjacent teeth and/or hard or soft tissue	Breakage of root(s) and related tooth fragments
Paresthesia or numbness of tongue, and/or mouth, and/or face	Swallowing and/or aspiration of objects
Fracture of Mandible (lower jaw) or Maxilla (upper jaw)	Allergic reaction to medications
Opening between mouth and sinus or mouth and nose	Trismus (jaw pain or difficulty to open mouth)
Fragment of tooth in maxillary sinus	Failure of treatment to accomplish its purpose
Incomplete removal of tooth	Death (in rare instances)
Dry socket	Bacterial Endocarditis
Loss of teeth	Loss of bone

Additional oral surgery; hospitalization and/or further treatment may be required in the event of any complication

By signing, I acknowledge that I have read this consent, or that it has been read to me. I also understand the information contained on this consent form. I was given adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienist, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

_____ _____

Signature of Patient or Parent / Guardian Date

_____ _____ _____

Print Name Name of Patient if patient is a minor (Please Print)

_____

DOB

Finally, we want to thank you for entrusting us with serving you and hope you will tell others about your experience with us!

Dr. John T. Mahoney and Team

John T. Mahoney, DDS **Financial Policy Agreement**

FAMILY DENTISTRY

We take your smile to heart

2117 Old Jeanerette Road
New Iberia, LA 70563

Telephone: 337-365-5865
Fax: 337-365-6137

We strive for open communications both among ourselves as well as with our patients. We take your smile to heart and want to help you to have a smile that will last a lifetime.

We will present each patient with a treatment estimate and carefully review this estimate with you. We do our very best to notify you if there are any changes to that estimate.

It's with that understanding that we have these financial policies.
Please initial on the line in front of each section after you've read and understood that section.

____ **All patients:** are required to pay at the time of service. If you have insurance, you are responsible for your co–payment.

____ **Payment Options**:

- Cash, checks, money orders
- 5% pre–pay discount for any amount over $300.00
- Visa, Master card, American Express, Discover
- Care Credit

If you would like to choose electronic (paperless) billing, please enter your email address here:
_____**If you wish to opt out, please check here** ☐

____ **Dental Insurance:** Our office is out of network with the insurance companies. We gladly file your dental insurance claims for you and collect your out–of– pocket or co–payment on the date of service. We ask that you remember that the estimate we provide to you is simply that, an estimate. **The agreement with the insurance company is between you, the patient, and the insurance company and the insurance company decides how much of our fee they will pay; our fees remain the same as the estimate provided to you.** Therefore, **you are responsible for any amount not covered by your insurance company.** If your insurance company has not paid your dental claim after 60 days, you become responsible for the balance. All charges you incur are your responsibility regardless of your insurance coverage. We will do our best to help you maximize your coverage.

____ **Confirmation Policy:** 24 hour notice is required to change an appointment. You will receive a telephone call, text or email from our office reminding you of your appointment one to two days prior to your scheduled appointment. If we verbally speak with you or you confirm your appointment through text or email, your appointment is considered confirmed. However, if we are not able to speak directly with you or get a confirmation directly from you, we may cancel your appointment time. Your appointment time is a time that is reserved specifically for you therefore we MUST receive a confirmation from you.

____ **Missed Appointments:** As previously stated, a 24 hour notice is required to change an appointment. Less than a 24 hour notice may result in a $50.00 charge. Multiple missed appointments will result in requiring a non–refundable deposit fee of $50.00 on the account at all times which may be applied to your dental appointment.

____ **NSF checks**: NSF checks incur a $25.00 charge on the unpaid balance for the 1st occurrence. If NSF checks are not paid with cash, we do turn them over to the DAs office.

____ **Divorce:** In the unfortunate case of divorce or separation, Louisiana Community Property Laws state the party (husband & wife) responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the responsible party for the subsequent charges.

____ **Past Due Accounts:** Accounts that become 60 days past due may be subject to interest fees. If no written payment agreement is in place, the account may be referred to a collection agency. At that time, you will be responsible for all collection costs, lawyer's fees, and court costs incurred as a result of the process.

____ **Photo Release Policy:** I grant Dr Mahoney and team the unrestricted right to use and publish photographs of me, or in which I may be included for advertising or any other purpose in any manner or medium, and to alter the same without restriction. I hereby release the photographer from all claims and liability relating to photographs.

_____ _____
Print Name Signature

_____
Date