Best viewed with Adobe Reader. If these buttons do not work, please save this file to your computer, open with Adobe Reader, fill out the form, and attach it in an email to: office@mikerobichauxdds.com

Welcome To Our Practice

We appreciate you 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 assistance, please ask us - we will be happy to help.

ABOUT YOU

Today's Date:

Name: I prefer to be called Sex: M F

Marital Status: Birth date: Age: SSN#:

Home Address: City: State: ZIP:

Home Phone: Work: ext. Mobile: email:

Employer: How long there?

Occupation:

Employer's Address:

Whom may we thank for referring you?

PERSON RESPONSIBLE FOR ACCOUNT (if other than yourself)

Name: Relationship:

Billing Address: SSN:

Home Phone: Work Phone: Ext. Employer:

How long there?

Occupation:

SPOUSE INFORMATION

His/Her Name: Birth date: SSN#:

Employer: Work Phone: Ext.

Emergency Contact Name: Phone:

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: Phone: Group/Policy #:

Insurance Co. Address:

Insured's Name: Insured's SSN#:

Insured's Birth date: Relation:

Insured's Employer: Employer's Address:

Secondary Insurance

Insurance Co. Name: Phone: Group/Policy #:

Insurance Co. Address:

Insured's Name: Insured's SSN #:

Insured's Birth date: Relation:

Insured's Employer: Employer's Address:

MEDICAL HISTORY INFORMATION

Name of Physician: Phone:

Allergies/Hay Fever	Fainting or Dizziness	Asthma	Radiation Treatment
Emphysema	**HIV*/AIDS**	Glaucoma	Ulcers
Heart Surgery*	Sinus Problems	Mental Disorders	Chemotherapy
Rheumatism	**Artificial Joints***	Thyroid Problems	**Heart Murmur***
Anemia	Fever Blisters/Cold Sore	Cancer	Respiratory Problems
Epilepsy or Seizures	Venereal Disease	Diabetes	**Stents (Location)***
Hepatitis	Kidney Problems	Stroke	**Mitral Valve Prolapse***
Shortness of Breath	**Artificial Heart Valves***	Tuberculosis	Yellow Jaundice
Angina	Frequent Cough	Chemical Dependency	**MRSA***
Excessive Thirst	Liver Problems	**Heart Pace Maker***	Rheumatic Fever
High Blood Pressure	**Surgical Shunt***	**Heart Infection***	
Sickle Cell Disease	Arthritis	**Heart Disorder (Congenital)***	

* **This condition may require antibiotic premedication for certain dental procedures.**

Do you have any health problems that were not listed above or need further clarification? Y N

If yes, explain:

Are you now under the care of a physician? Y N
If yes, explain:

Have you been admitted to a hospital or needed emergency care during the past two years? Y N
If yes, explain:

Are you taking any medications? Y N If yes, list:

Are you allergic to any medications or substances? Y N If yes, list:

Are you using or have you used tobacco? Y N If yes, explain:

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X Date:

Signature of patient, parent or guardian

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic	

Total score

DENTAL HEALTH QUESTIONNAIRE

The cornerstone of our practice is the examination process. Our first task is to help you identify what it is that you want, both in the short term and in particular, for the long term. We feel everyone deserves to know the state of their dental health, what is moving them away from health, and the choices available to restore their oral health. If your first appointment is for a cleaning or an emergency visit, your exam will likely be cursory with limited x-rays. If you are here for a comprehensive exam, we will examine your soft tissues, teeth, gums, and chewing system. Depending on the clinical findings, we'll take appropriate x-rays, impressions for models of your teeth, and photographs.

Excellence in dentistry begins with a careful diagnosis and treatment plan. Once all your diagnostic records have been completed and evaluated, we will visit with you and review the findings, discuss your options, and together, create a personalized plan. It is important to note that once we have agreed on your plan, that quality is the constant and time is the variable. You always control how far and at what pace we'll proceed.

Please help us better understand your dental health needs and goals by answering the following questions (check the best answer):

1. I have a fear of going to the dentist.

2. My mouth and teeth are comfortable.

3. I am with the appearance/condition of my teeth.

4. I think my present state of dental health is .

5. I would say that my main concerns with my dental health are:

6. I am interested in a smile evaluation and personalized treatment plan to enhance my smile.
Y N

7. Have you had a *full mouth* set of x-rays (other than routine cavity detecting x-rays) within the last 3 years?
Y N

APPOINTMENTS

Because we recognize the value of your time, you can expect us to see you at the appointed time, 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 time 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 hour 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 the loss of time. 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 the treatment.

Payment Options

1. For your convenience we accept **Cash**, **Check**, **Visa**, **MasterCard** and **Discover**.
2. We also offer short and long-term financing options.
3. Feel free to discuss your financial concerns with any of our staff. We are committed to helping you remove all barriers on your journey to health.

For patients with Dental Insurance

As a courtesy, we will assist you in getting your benefits from your insurance company. For some treatment we may ask for payment in full. For other treatment, we will estimate your share of the

anticipated charges and ask for that payment at the time of treatment. Should you need special arrangements for your share, please discuss this with our business manager.

Finance Charges

If your balance is not paid within 90 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. Robichaux. 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. Robichaux to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Photography Release

I authorize Dr. Robichaux 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 in an educational setting as well as 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 comply with the Office Financial Policy.

I understand and agree to the General Consent to Treatment.

I authorize the Release of Information

Photographs taken of me may be used in a teaching environment.

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

X Date:

Signature of patient, parent or guardian