# Welcome to College Family Dentistry! Expert Care. Gentle Touch.

Date: _____ Patient Name: _____ Birthdate: _____ Age: _____
SSN: _____ Drivers License Number: _____ Occupation: _____
Marital Status: Single__ Married__ Divorced__ Widowed__ Spouses Name: _____ Work Number: _____
Home Address: _____ City/ State: _____ Zip: _____
Home Number: _____ Cell Phone: _____ Alternate Number: _____
E- Mail Address: _____
Employer Name and Address: _____ City/ State: _____ Zip: _____
Do you have Dental Insurance: Yes No With Whom? _____
Person Responsible for Account: _____ Relationship: _____
SSN: _____ Birthdate: _____ Home Number: _____
Home Address (if different): _____ City/ State: _____ Zip: _____
Occupation: _____ Work Number: _____
Referred By: _____ Physician and Phne Number: _____
Nearest Relative Not Living With You: _____ Relationship: _____ Address: _____ City/ State: _____ Zip: _____ Are you currently having dental problems? _____

**Circle yes or no to the following questions:**

1. Are you presently under the care of a physician or have you had any recent surgeries? Yes No
2. Have you ever had high blood pressure? Yes No
3. Has a physician ever said you had heart trouble? Yes No
4. Do you require premedication for dental visits? Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? Yes No
6. Have you ever had an anesthetic (either local or general)? Yes No
7. Are you interested in being sedated for your dental visit? Yes No
8. Has a physician or dentist ever said you had a tumor, cancer or radiation to the head/neck area? Yes No
9. Are you allergic to Penicillin, Novocain or any other medicine? Yes No
   If so, what? _____
10. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? Yes I
    If so, what? _____

**Do you have or ever had:**

1. Rheumatic fever/heart disease? Yes No
2. Joint Replacement? Yes No
3. Anemia, leukemia or low platelets Yes No
4. Epilepsy or convulsions? Yes No
5. Asthma or hay fever? Yes No
6. Tuberculosis Yes No
7. Diabetes? How long Yes No
8. Kidney trouble? Yes No
9. Liver trouble or jaundice? Yes No
10. Thyroid trouble or goiter? Yes No
11. Syphilis? Yes No
12. Fainting or dizziness? Yes No
13. Glaucoma? Yes No
14. Arthritis? Yes No
15. HIV AIDS? Yes No
16. Stroke? Yes No
17. Stomach ulcer? Yes No
18. Heart murmur? Yes No
19. Prostate trouble? Yes No
20. Hepatitis? Yes No
21. Eczema or hives? Yes No
22. Osteoprosis? Yes No
23. Are you pregnant? Yes No

**Are you now taking:**

1. Drugs for high blood pressure? Yes No
2. Drugs for sleep? Yes No
3. Cortisone, steroids or ACTH? Yes No
4. Anticoagulants or blood thinner?. Yes No
5. Tranquilizers or sedatives? Yes No
6. Antibiotics? Yes No
7. Insulin? Yes No
8. List other: _____

9. Have you been under the care of a physician for any major illness or injury other than those noted above. If so, list.

**I Understand That Payment Is Due At Time Of Service.**
**If insurance does not pay then I know the balance is my responsiblity.**
**I will pay today by: : CASH ___ CHECK ___ CREDIT CARD ___**
**If account goes to collections a 40% fee is added to account. NSF fee $25.**
I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA

# College Family Dentistry

4616 Concord Ave
Baton Rouge, LA 70808
225-926-4640

## CONSENT TO PERFORM DENTISTRY

I hereby authorize and direct Dr. Seth O'Shee and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of plastic "sealants" to the grooves of teeth.
C. Treatment of diseased or injured teeth with dental restorations (root canals, fillings and crowns).
D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures and implants)
E. Removal (extraction) of one or more teeth.
F. Treatment of diseased or injured oral tissues (hard and/or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
I. Use of general anesthesia to accomplish the necessary treatment.

I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxyge may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these a swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understar that there are rare potential risks seen as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing anc heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

I also authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

I will be advised that the success of dental treatment to be provided will require that the patient and the parents follow the post operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; a I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____

Print Patient's Name: _____

Signature: Patient or Parent/Guardian: _____

# WAIT TIME & 24 HOUR CANCELLATION

Welcome to College Family Dentistry. We know you have options when it comes to your dental care and we appreciate you choosing us. At College Family Dentistry, we strive to have short wait times. Also, we ask that you be prompt to your appointments so we can achieve this goal Please inform the front desk if you are experiencing an excessive wait time. If you are unable to keep your appointment, please notify our office at least 24 hours prior to your appointment to allow us to accommodate other patients. We appreciate your assistance and look forward to serving you.

X_____

# Whitening for Life Program!

We are delighted you have chosen our practice, and look forward to helping you with your dentistry for many years to come. We feel that every patient in our practice deserves to have a smile they can be proud of. We are excited to offer ou patients a unique program we call Whitening for Life.

When you come in our office for your examination and/or cleaning, we will provide you with Sheer White Strips for a on time charge of $99. Then at each six month preventive visit, we will give you complementary touch up bleach strips. Thi ensures that you will be able to keep your teeth bright and beautiful for Life!

All we ask in return is:

- You keep your six month preventative visits current. Your long term dental health is as important to us as it is to you. Our patients have found that these six month visits help greatly reduce emergencies. That is why we a happy to provide this extra bonus for our patients who are committed to their dental health.

- You are awarded free bleach FOR LIFE as long as you continue your hygiene visits every 6 months. If you miss a hygiene appointment, you will be able to pay a fee of $50 to re-enlist in the Whitening for Life program. you do not come in for 1 year, you can pay a fee of $99 to re-enlist in the Whitening for Life program.

- Additional bleach may be purchased between visits for $30 (1 strip per arch).

- Be aware that your bleach must stay in the refrigerator.

We appreciate the opportunity to serve you, and look forward to seeing your bright smile for many years to come!
I understand the Whitening for Life program requirements, and would like to enroll.

Sign if interested:_____Date:_____

*Whitening for Life membership valid for as long as College Family Dentistry is open and is not transferable upon the sa of the practice.