Southeast
FAMILY DENTISTRY

PATIENT APPOINTMENT NOTICE

Southeast Family Dentistry will always do our best to schedule patients for appointments in a timely and medically appropriate manner. The best patient care is achieved when appointments are kept and dental services can be made available to as many patients in need of care as possible. Our policy is that if a patient either fails to keep a scheduled appointment and does not call or if a patient cancels numerous appointments with less than 48 hour notice, then we have the right and discretion to cease further appointment scheduling and care for that patient. After all, an appointment time has been taken and not used to the fullest capacity for an emergency patient or someone that has a great need for dental care. **YOU SHOULD ALWAYS MAKE EVERY EFFORT TO KEEP THE APPOINTMENT YOU HAVE COMMITTED TO.** Should your dental health require monitoring, it is very important for you to maintain appropriate and timely follow-up care. Your failure to do so could lead to overall declining health. **ONCE AGAIN, YOU SHOULD MAKE EVERY EFFORT TO KEEP ALL APPOINTMENTS TO ENSURE WE CAN PROVIDE THE CARE THAT YOU NEED.**

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF SOUTHEAST FAMILY DENTISTRY'S APPOINTMENT SCHEDULING POLICY AND UNDERSTAND THE IMPORTANCE OF KEEPING SCHEDULED APPOINTMENTS SO AS TO REMAIN IN COMPLIANCE WITH THE POLICY.

SIGNATURE _____ DATE _____

PATIENT INFORMATION

Michael French DDS
John Lally DDS

Date_____ (PLEASE USE INK)

Patient's Name_____
Last First Middle

Mailing Address_____ City_____State_____Zip_____

Home phone _____ Cell phone _____ May we text? ☐ Yes ☐ No

Email _____ Birthdate_____ Social Security #_____

Employer _____ If student, list school_____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you? _____

Responsible Party_____ _____
Last First Middle Marital Status

Address_____ City_____State_____Zip_____

Social Security Number _____ Birthdate _____ Relationship to Patient_____

Spouse's Name_____
Last First Middle

Spouse's Employer_____ Occupation_____ Work phone_____

INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security Number_____

Insured D.O.B._____

Insurance Company _____ Group Number_____ Local Number_____

Insurance Company Address_____

Do you have dual coverage? ☐ Yes ☐ No If yes:

Insured's Name_____ Insured's Social Security Number_____

Insurance Company _____ Group Number_____ Local Number_____

Insurance Company Address_____

Insured's Employer_____

EMERGENCY INFORMATION

Local Friend or Relative not living with you_____ Phone #: _____

Street Address_____ City_____State_____Zip_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (Date & initial _____ _____ _____ _____ _____

DENTAL/MEDICAL HISTORY

Patient's name _____

1. Are you experiencing pain or discomfort?.....Yes No
2. Are you in good health?.....Yes No
3. Has there been a change in your general health within the last year?.....Yes No
4. Are you under the care of a physician?.....Yes No
   If so, what condition is being treated? _____
   Physicians' Name_____ Phone #_____
5. Have you been hospitalized or had a serious operation or illness within the past 5 years?.....Yes No
6. Do you have or have you had any of the following diseases or problems? Please circle:

AIDS	Epilepsy	Latex Allergy
Allergies	Fainting or Dizzy Spells	Liver Disease
Anemia	Glaucoma	Mitral Valve Prolapse
Angina Pectoris	Hay Fever	Nervousness
Arthritis	Heart Disease/Attack	Pain in Jaw Joints
Artificial Joint	Heart Failure	Psychiatric treatment
Artificial Heart Valve	Heart Murmur	Rheumatic Fever
Asthma	Heart Pacemaker	Rheumatism
Blood Transfusion	Heart Surgery	Scarlet Fever
Bruise Easily	Hepatitis A (Infectious)	Sickle Cell Disease
Cardiac Pacemaker	Hepatitis B (Serum)	Sinus Trouble
Chemotherapy	HePC	STD or VD (Syphilis, Gonorrhea)
Cold Sores	Herpes	Stroke
Congenital Heart Lesions	High Blood Pressure	Tuberculosis
Cough	HPV	Ulcers
Diabetes	Jaundice	X-Ray or Cobalt Treatment
Emphysema-COPD	Joint Replacement Date_____	
	Kidney treatment	

7. Are you taking any drug or medicine?.....Yes No
   If so, what_____
8. Are you allergic or have you reacted adversely to any drugs or medicine?.....Yes No
   If so, which drugs_____

Aspirin	Demerol	Nitrous Oxide	Percodan
Codeine	Erythromycin	Novocain or Holocaine	Scopolamine
Coumadin	Local Anesthetic	Other Antibiotics	Sleeping Pills
Darvon	Nembutal/Seconal	Penicillin	Tetracycline
			Valium

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?.....Yes No
10. Do you ankles swell during the day?.....Yes No
11. Have you ever had any serious trouble associated with any previous dental treatment?.....Yes No
    If so, what_____
12. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?.....Yes No
13. Do you have a disease, condition, or problem not listed above that you think I should know?.....Yes No
    If so, please explain_____
14. FOR WOMEN ONLY: ARE YOU PREGNANT?.....Yes No
    If yes, what month?_____ Are you taking birth control pills?.....Yes No

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

PATIENT_____ DATE_____ WITNESS_____

RESPONSIBLE PARTY_____ RELATIONSHIP TO PATIENT_____

Photo Release Form

Southeast Family Dentistry, PLLC

601 N 2nd Street McGehee, AR 71654

Permission to Use Photograph

I grant to Southeast Family Dentistry, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize Southeast Family Dentistry, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Southeast Family Dentistry may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature _____

Printed name _____

Date _____

Signature, parent or guardian _____ (if under age 18)