



Member of : Acadiana Dental Distric Assoc., Louisiana Dental Association
Academy General Dentistry, American Dental Association
American Academy Cosmetic Dentistry, Fellow Academy Comprehensive Esthetics

WELCOME TO SMILES BY SOILEAU

PERSONAL info

Name _____ Social Security # _____ Birth Date _____

Name of spouse _____ Employer _____

Home Address _____

City/ State/ Zip/ _____

Who may we thank for referring you to our office? _____

Newspaper Ad _____ Newspaper Insert _____ Valpak _____ Seminar _____

CONTACT info

Cell # _____ Home # _____ Work # _____

Email _____

Emergency Contact: Name _____ Number _____

INSURANCE coverage

Insurance Company Name: _____

Policy Number: _____

Name of covered employee: _____ Social Security of cover employee: _____

AUTHORIZATION & release

I authorize Dr. Soileau or his employees to release any information concerning my dental treatment or my child's dental treatment to third party payers and/or other medical/dental offices.

Signature of patient or legal guardian

Medical History

Name _____ Date _____

☞ Medications: (Including “over the counter” i.e. aspirin, vitamins)

☞ Allergies: () Penicillin () Codeine () Latex () Other _____

☞ Heart Problems:

- () High Blood Pressure (What is your usual Blood Pressure? ____/____)
- () Heart Murmur () Pace Maker
- () Stroke () Rheumatic Fever
- () Heart Attack () Angina
- () Heart Valve

Do you need to take antibiotics before a dental appointment? Yes () No ()

☞ Bleeding:

Do you bleed easy? Yes () No () Are you on blood thinners? Yes () No ()
Do you have Hepatitis? Yes () No () If so, which one? A () B () C () D () Jaundice ()

☞ Diabetes: Yes () No () If yes, is your diabetes under control? Yes () No ()

☞ Breathing Problems

- () Allergies () Sinus Problems
- () Asthma () Bronchitis Snoring () *Ask your spouse!*

Do you need help sleeping? Yes () No () If so, what do you do? _____

Were your tonsils removed? Yes () No () Do you use a CPAP for sleeping? Yes () No ()

Do you wake up tired? Yes () No () How often do you wake up at night? _____

Do you have sleep apnea? Yes () No () When were you diagnosed? _____

*Would you like information on an FDA approved treatment for sleep apnea? Yes () No ()

☞ Pregnancy:

Are you pregnant or breast feeding? Yes () No () If so, when is your due date? _____

☞ Cancer: Do you (or have you ever had) cancer? Yes () No ()

When diagnosed? What kind? _____

How are you or were you being treated? Surgery () Chemo () Radiation ()

☞ General Questions:

Do you smoke? Yes () No () How often/ how many packs per day? _____

Would you be interested in Sedation for particular procedures? Yes () No ()

☞ Nerves/Muscles/Bones:

Can you recline back comfortably in the dental chair? Yes () No ()

Do you have a Neuromuscular Disorder? Yes () No () If so, what is it? _____

☞ Immune System:

Lupus () Organ transplant () HIV () AIDS () ARC ()

Tony Soileau DDS

337.234.3551

tony SOILEAU DDS smilesbysoileau.com



Consent for Treatment

By state law we are required to make an attempt to inform patients of possible complications, even though rare, which could result from anesthesia, local and/or sedation.

- Allergic reactions which could require hospitalization.
- Cardiac arrest, which could result in brain damage or even death.

It must be understood that these complications are extremely rare and every possible precaution will be taken to prevent their occurrence as well as to treat them successfully should they occur.

The most common, even though rare, complications resulting from tooth extractions, periodontal therapy, cyst removal, biopsies, filling, root canal therapy, crowns, veneers, bridges, etc, are:

- Bleeding heavy enough to stop therapy.
- Injury to adjacent teeth and fillings.
- Post-operative infection requiring additional treatment
- Possibility of a small piece of root being left in the jaw when its removal would require extensive surgery.
- Fracture or breakage of the jaw.
- Post-operative discomfort and swelling which may necessitate several days of home recuperation.
- Stretching of the corners of the mouth resulting in cracking and bruising.
- Nerve injury, sensory and/or motor, adjacent or on the side of the surgical site, especially underlying the teeth resulting in numbness of the palate, lips, tongue, chin, face, or other anatomical structures in the head and neck.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- Tooth sensitivity, which may require additional treatment.
- Tooth mobility.
- Recession of the gingival (gums).

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Patient or guardian's signature

Date

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Witness

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Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your Notice of Privacy Practices Acknowledgement containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the contained address to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

Photographic Release

I _____, hereby authorize Dr. Tony Soileau to take photographs, slides, and/or video of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television, etc) and professional publications (dental magazines and journals). I do not expect compensation, financial or otherwise, for the use of the photographs, slides, or videos.

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tony SOILEAU DDS

Financial Agreement

I agree to pay Dr. Tony Soileau FOR PROFESSIONAL SERVICES RENDERED, OR TO BE RENDERED, at the time the service is performed unless other arrangements have been made in advance. I understand that any balance past due over 30 days from the first billing date will be subject to an interest charge of 1.5% per month (18% annual rate) if elect not to pay within 30 days.

I also understand that insurance benefits assigned to Dr. Tony Soileau must be paid within 60 days from the date of insurance billing. If insurance has not paid within 60 days I agree to pay Dr. Tony Soileau the full balance within the credit limits of the office. Any payment received by Dr. Tony Soileau after my balance is paid will be refunded to me. I understand that Dr. Tony Soileau's office cannot be responsible for collecting my insurance claim or for negotiating a settlement on a disputed claim. I understand I am ultimately responsible for this account no matter what my insurance may or may not pay.

I agree to give at least **24 hours** notice if I need to change my appointment. If our office isn't notified within at least 24 hours, you may be subject to a \$25 fee.

ALL patients are **REQUIRED** to have an appointment. We don't accept walk-ins, **NO** exceptions!!!

I understand that fee estimates quoted are based on all appointments being kept. The fee will be higher if there are frequent short notice cancellations or appointment changes. Fees quoted will remain valid for 90 days.

I understand that if it is necessary for Dr. Tony Soileau to retain the services of an attorney to collect my unpaid balance I will be responsible for all court cost, attorney fees, and any other collection fees which may be incurred as a result of my account being turned over for collections as allowed by the State of Louisiana.

I agree to pay a fee of \$25.00 for a check returned N.S.F.

I have read and understand the above agreement.

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The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.