Brittany Lamoureux, DMD
Ali Fedel Mahdy, DDS
WELCOME

PATIENT INFORMATION

Name _____ Preferred Name _____
First *Last*
Birth Date _____ Social Security # _____ Gender _____ Marital Status_____

Phone Numbers: Home_____ Cell_____ Work_____

E-mail _____

Address _____ City_____

Zip_____ Employer_____

Occupation_____

Who is financially responsible for this account _____

Who may we thank for referring you _____

Emergency Contact _____ Phone #_____ Relationship_____

DENTAL INSURANCE INFORMATION

Primary Insurance Plan Name_____ Group#_____

Subscriber ID _____ Subscriber Birth Date _____

Name of Subscriber _____ Is Subscriber a Patient? _____

Patient's Relationship to Insured: _____ Self _____ Spouse _____Child _____ Other

Secondary Insurance Plan Name_____

Subscriber ID _____ Subscriber Birth Date _____ Group#_____

Name of Subscriber _____ Is Subscriber a Patient?
_____

Patient's Relationship to Insured: _____ Self _____ Spouse _____Child _____ Other

DENTAL HISTORY

- How long has it been since your last dental visit?_____
- Do you clench or grind your teeth?_____When?_____ Do you wear a nightguard?_____
- How often do you brush?_____Floss?_____
- Are you unhappy with your past dental treatment?____Why?_____
- Is there anything you would like to change about the appearance of your smile?_____Yes_____No
  Please explain:_____

Health Information

Name_____
Date_____

Please indicate if you currently have or have a history of any of the following conditions:

Yes No
- □ □ **Latex Allergy**
- □ □ **Penicillin/Amoxicillin Allergy**
- □ □ **Sulfa Drug Allergy**
- □ □ **Alcoholism**
- □ □ **Anemia**
- □ □ **Angina Pectoris (Chest Pain)**
- □ □ **Arthritis/Rheumatism**
- □ □ **Artificial Joints**
- □ □ **Artificial Heart Valve**
- □ □ **Asthma**
- □ □ **Cancer (IV bisphosphonate)**
- □ □ **Chemotherapy**
- □ □ **Congenital Heart Lesions**
- □ □ **Cold Sores/Herpes**
- □ □ **Diabetes**
- □ □ **Eating Disorders**
- □ □ **Emphysema**
- □ □ **Epilepsy**
- □ □ **Excessive Bleeding**

Yes No
- □ □ **Fainting/Seizures**
- □ □ **Glaucoma**
- □ □ **Head Trauma**
- □ □ **Heart Disease**
- □ □ **Heart Murmur**
- □ □ **Heart Surgery**
- □ □ **Hemophilia**
- □ □ **Hepatitis A**
- □ □ **Hepatitis B**
- □ □ **Hepatitis C**
- □ □ **High Blood Pressure**
- □ □ **HIV Positive**
- □ □ **Kidney Disease**
- □ □ **Mitral Valve Prolapse**
- □ □ **Nervous Disorders**
- □ □ **Osteoperosis/Osteopenia (bisphosphonate use?)**

Yes No
- □ □ **Pacemaker**
- □ □ **Psychiatric Treatment**
- □ □ **Radiation Treatment**
- □ □ **Respiratory Problems**
- □ □ **Sinus Problems**
- □ □ **Stroke**
- □ □ **Thyroid Problems**
- □ □ **Tuberculosis**
- □ □ **Vertigo**
- □ □ **Other:**_____

_____

_____

□ □ **Do you need to pre med prior to dental treatment?**
- □ **Amoxicillin**
- □ **Clindamycin**
- □ **Keflex**

▪Name of Physician:_____ Phone:_____
▪Date of last physical Exam: _____
▪Are you currently taking any drugs or medications? Please list:_____
_____

▪Have you been admitted to a hospital or needed emergency care during the past two years?
Yes____ No____ If yes, please explain:_____

▪Surgeries or any health problems that need further clarification? If yes, please explain:_____
_____

***Please do not write below this line. Medical history update for office use only.**

Medical History Update

Date	Changes	Signature
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

Dr. Lamoureux's and Dr. Mahdy's

Office Policies

Dental Insurance
We are happy to bill your dental insurance carriers on your behalf at no charge. We do not accept Denti-Cal or HMO type of dental plans. The benefits that are actually paid by insurance carriers vary widely from carrier to carrier and depend primarily on the benefits negotiated and paid for by your employer, union, or other group with the insurance carrier. Very often we can provide you with an approximate estimate of your coverage prior treatment. However, we cannot guarantee what your insurance will pay. **Any treatment rendered to you will be your financial responsibility irrespective of what your insurance pays.** With your signature (below) you accept our policy and authorize Brittany Lamoureux, DMD to: 1) Bill your insurance carriers on your behalf;
2) Release any information regarding treatment at this office to your insurance carriers; 3) Authorize payment directly to Brittany Lamoureux, DMD any insurance benefits due to services rendered.

Payments in Full
Payment is required on the day of your appointment. If you have dental insurance, your estimated co-payment and deductible are due on that day.

Payment Option
For your convenience, we accept cash, check and all major credit cards. (Visa, MasterCard, American Express and Discover). In addition, our office offers easy to use financing programs through Care Credit finance company. Inquire at the front desk if you would like more information on our Care Credit Financing.

Notice of Privacy Practices
Our office obeys federal and state law regarding the privacy of your health information. With your signature below you Acknowledge the Receipt of our office's Notice of Privacy Practices.

Dental Material Fact Sheet
The Dental Board of California has prepared a fact sheet to summarize information on the most frequently used restorative dental materials. With your Signature below you acknowledge that you read the Dental Material Fact Sheet. **Initials**

Dr. Lamoureux's Cancellation Policy

A scheduled appointment is a commitment of time between you and our doctor/hygienist. When appointments are missed or cancelled with **less than 48 hours notice**, it results in a missed opportunity to schedule another patient in need of dental treatment. We ask that when you schedule an appointment, you make every effort to keep that commitment. We understand that personal emergencies sometimes occur and we always take that into consideration. Our office usually confirms appointments 48 hours in advance. Please advise the office if you need to change your appointment at that time. **We reserve the right to charge $150 for appointments missed or cancelled without a 48 hours prior notice.**

Initials _____

Consent For Services

I, the undersigned, hereby authorize Dr. Lamoureux to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of Patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk. If I ever have any change in my health, I will inform the doctor or hygienist at the next appointment. I have read the above conditions of treatment and agree to their content.

Signature of patient, parent, guardian: _____ Date: _____
Witness:_____