Acadiana Smiles
Giving Acadiana a Reason to Smile

Mark A. Broussard, DDS Stuart F. Taylor, DDS Lara B. Henderson, DDS
Family Dentistry

W E L C O M E

Thank you for selecting our DENTAL TEAM! We will always offer you the most up to date care available. To help us meet your dental needs, please fill out these forms for us. Yes, we hate forms too, but this information is important. Thank you for your cooperation.

PATIENT INFORMATION

Name_____ Soc. Sec. # _____ Birth Date _____
Wish to be called _____ ❑Male ❑Female ❑Single ❑ Married
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____ Ext. _____
Your Employer _____ Your Occupation _____
Insurance Company Name _____ Date of coverage _____

Name of spouse _____ Date of Birth _____
Spouse employed by _____ S.S.# _____
Name of spouse's dental insurance company _____
Who will be paying for dental services? _____
Whom may we thank for referring you to our office? _____
Please circle which Dr. you wish to see Dr. M. Broussard, Dr. S. Taylor or Dr. L. Henderson

HOW CAN WE CONTACT YOU?

Cellular Phone _____ Pager _____
Email _____
Where do you prefer to receive calls? ❑Home ❑Work ❑Cellular ❑Pager
When is the best time to reach you? Time _____ Days ❑M ❑T ❑W ❑Th ❑F
Please list names and phone numbers of three people who will know how to reach you in case of an emergency.
Name: _____ Phone Number _____
Name: _____ Phone Number _____
Name: _____ Phone Number _____

DENTAL CONCERNS

WHAT DID YOU NOT LIKE ABOUT YOUR PAST DENTAL APPOINTMENTS?

❑ WAS THE TREATMENT UNCOMFORABLE?
❑ WAS THE STAFF UNFRIENDLY?
❑ WERE THE FEES NOT EXPLAINED BEFORE YOUR APPOINTMENTS?
❑ ANYTHING WE HAVE NOT THOUGHT OF? _____

WHAT ARE YOUR FEELINGS ABOUT YOUR:

FRONT TEETH

ARE YOU HAPPY WITH THEIR COLOR? ❑YES ❑NO
ARE YOU HAPPY WITH THEIR LENGTH? ❑YES ❑NO
ARE THEY CROWDED OR CROOKED? ❑YES ❑NO
ARE YOU HAPPY WITH THEIR OVERALL APPEARANCE? ❑YES ❑NO
ANYTHING ABOUT THEM YOU WOULD CHANGE? _____

BACK TEETH

ARE THEY SENSITIVE TO HOT OR COLD FOODS? ❑YES ❑NO
DO THEY TRAP FOOD WHEN YOU EAT? ❑YES ❑NO
ANYTHING ABOUT THEM YOU WOULD CHANGE? _____

GUMS

DO THEY EVER BLEED? ❑YES ❑NO
ARE THEY SENSITIVE? ❑YES ❑NO
ARE YOU SEEING A GUM SPECIALIST? ❑YES ❑NO
IF YES WHO:_____
DO YOU FEEL YOU HAVE BAD BREATH? ❑YES ❑NO
ANYTHING ABOUT THEM YOU WOULD CHANGE? _____

MISSING TEETH

DO YOU HAVE ANY MISSING TEETH? ❑YES ❑NO
ARE YOU WEARING A REPLACEMENT? ❑YES ❑NO
IS YOUR DENTURE OR PARTIAL UNCOMFORTABLE? ❑YES ❑NO
ANYTHING ABOUT THEM YOU WOULD CHANGE? _____
OVERALL On a scale of 1-10, how would you rate the health of your teeth?
1 2 3 4 5 6 7 8 9 10

WHAT IS THE FIRST THING YOU WOULD LIKE FOR US TO HELP YOU WITH?

List in order of importance: _____

WHAT CAN WE DO TO MAKE YOU FEEL MORE AT HOME?

❑ WOULD YOU LIKE AN IPOD TO LISTEN TO?
❑ WILL YOU NEED BLANKETS TO HELP WITH THE TEMPERATURE?
❑ WILL YOU NEED A PILLOW TO SUPPORT YOUR NECK?
❑ ANYTHING WE HAVE NOT THOUGHT OF? _____

MEDICAL CONCERNS

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. ***This information is very important***. Thank you in advance for your cooperation. Indicate which of the following you have had or have at the present.

HEART PROBLEMS

Heart Disease / Attack	❑YES	❑NO
Heart Failure	❑YES	❑NO
Angina Pectoris	❑YES	❑NO
Congenital Heart Disease	❑YES	❑NO
Heart Murmur	❑YES	❑NO
High Blood Pressure	❑YES	❑NO
Arteriosclerosis	❑YES	❑NO
Mitral Valve Prolapse	❑YES	❑NO
Artificial Heart Valve	❑YES	❑NO
Heart Pacemaker	❑YES	❑NO
Heart Surgery	❑YES	❑NO
Rheumatic Fever	❑YES	❑NO
Stroke	❑YES	❑NO

BLOOD PROBLEMS

Blood Transfusion	❑YES	❑NO
Hemophilia	❑YES	❑NO
Anemia	❑YES	❑NO
Sickle Cell Disease	❑YES	❑NO
Bruise Easily	❑YES	❑NO

GASTROINTESTINAL

Ulcers	❑YES	❑NO
Diabetes	❑YES	❑NO
Thyroid Problems	❑YES	❑NO
Liver Disease	❑YES	❑NO
Yellow Jaundice	❑YES	❑NO
Hepatitis A (Infectious)	❑YES	❑NO
Hepatitis B (Serum)	❑YES	❑NO

MUSCLES / BONES

Arthritis	❑YES	❑NO
Rheumatism	❑YES	❑NO
Jaw Joint Pain	❑YES	❑NO
Cortisone Medication	❑YES	❑NO
Artificial Joints (hips, knee, etc.)	❑YES	❑NO

BREATHING PROBLEMS

Emphysema	❑YES	❑NO
Chronic Cough	❑YES	❑NO
Tuberculosis	❑YES	❑NO
Asthma	❑YES	❑NO
Hay Fever	❑YES	❑NO
Allergies or Hives	❑YES	❑NO
Sinus Trouble	❑YES	❑NO
Sleep Breathing Disorder	❑YES	❑NO

GENERAL CONCERNS

Kidney Trouble	❑YES	❑NO
Venereal Disease	❑YES	❑NO
A.I.D.S/H.I.V. Positive	❑YES	❑NO
Epilepsy or Seizures	❑YES	❑NO
Fainting or Dizzy Spells	❑YES	❑NO
Psychiatric Treatment	❑YES	❑NO
Drug Dependence	❑YES	❑NO
Radiation Therapy	❑YES	❑NO
Chemotherapy	❑YES	❑NO
Glaucoma or Recent Eye Surgery	❑YES	❑NO
Ever take Fen-Phen?	❑YES	❑NO
Ever take osteoporosis medication?	❑YES	❑NO
Tobacco Habit	❑YES	❑NO

Physician's Name _____

Are you under a Physician's care at this time ❑YES ❑NO For what condition _____

Please list any medication you are now taking (including over the counter medications.) _____

_____

Have you ever had an allergic reaction to anything? ❑Penicillin ❑Codeine ❑Latex ❑Other_____

FOR WOMEN ONLY:

Are you pregnant? ❑YES, what month? _____ ❑NO Are you nursing? ❑YES ❑NO

Are you taking birth control pills? ❑YES ❑NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Dr. Broussard, Dr. S. Taylor and/or Dr. L. Henderson to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Broussard, Dr. S Taylor and/or Dr. L. Henderson to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Broussard, Dr. S. Taylor and/or Dr. L. Henderson to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name) _____ and further authorize and consent that Dr. Broussard, Dr. S. Taylor and/or Dr. L. Henderson choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility of payment for Dental Services provided in this office for myself or my dependents are mine, due and payable at the time of services are rendered unless financial arrangements have been made. **I (we) understand that my (our) credit history is subject to review**. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default 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 _____

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