PALM DENTAL CARE

Dental Office of JASON C. LEROUX D.D.S.

Dear New Patient,

Welcome to our Healthy Smile Family. We are genuinely pleased that you have chosen us for your dental care. The health of our patients and elimination of dental disease is our No. 1 priority.

Our practice has grown from the many referrals we have received. It gives us great satisfaction to have our patients believe in us enough to recommend us to family and friends. Making new friends and helping them achieve good dental health is what makes it all worthwhile.

In order to provide you with the best possible care, you must first have a thorough dental examination and evaluation. We will spend the first appointment performing a comprehensive exam. This procedure consists of all necessary x-rays, study models, examination of your teeth, gums and surrounding head and neck areas, and a complete medical and dental history. Your blood pressure may also be checked. A major emphasis will be placed on proper home care. At the conclusion of your dental examination, an appointment may be made for you to start any needed treatment.

Like a team, we believe in a group approach to dental care. In order for your treatment to be successful, you must keep your appointments to ensure proper continuity. You also will be asked to adhere to an effective oral hygiene program as well as being punctual with recall or maintenance appointments. **Your appointment is very important!** Be attentive to the date and time – it is reserved for you and you alone. *In our dental practice, when patients do not keep a scheduled appointment, the office has lost time that might have been given to patients who may be waiting to be seen. For this reason we do require* ***24 hour*** *advanced notification for appointment cancellation.*

Please avoid making changes to your scheduled appointment time. *If you're more than 15 minutes late, we reserve the right to re-schedule your appointment.*

Sincerely,

Dr. Jason Leroux

Please Complete The Following Confidential Information

Today's Date_____

Patient Name_____

Address_____

City _____State _____Zip_____

Home Phone ( ) _____Cell Phone ( ) _____ Work Phone ( ) _____

Patient Birth Date _____/_____/_____

S.S. Number _____ - _____ - _____

Email _____

Who may we thank for referring you to us? _____

Is another member of your family a patient in this office? Y N _____

In case of Emergency, **Please Contact**: _____

Responsible Person Account Information

Responsible Person's Name _____

Address_____

City _____ State _____Zip_____

Home Phone Number ( ) _____Cell Phone ( ) _____

Social Security Number _____-_____-_____

Date of Birth _____/_____/_____

Occupation _____

Employer _____ Phone Number ( ) _____

Business Address _____

City _____ State_____ Zip _____

Dental Insurance Information

Dental Ins. Company:_____

Insured's Name _____

Address_____

City _____ State _____Zip_____

Social Security Number _____

Date of Birth _____

Occupation_____

Employer_____

Business Address_____

City _____ State_____ Zip _____

Secondary Dental Insurance:_____

Insured's Name _____

Address_____

City _____ State _____Zip_____

Social Security Number _____

Date of Birth _____

Occupation_____

Employer_____

Business Address_____

City _____ State_____ Zip _____

Medical Information

1. Have you been a patient in the hospital during the past two years?.....YES NO
2. Are you now taking any medication or drugs? …… YES NO
   a. If yes, please list:_____
3. Have you taken any medication or drugs during the past two years including appetite suppressants – fen-phen fenluramine & phentermine) or dexfenfluramine or fenflurameine?..... YES NO
4. Have you been under the care of a medical doctor during the past two years or since taking any of the appetite suppressants named above? ……..YES NO
   a. Physician's Name_____ Phone # ( ) _____
   b. Physician's Address _____
5. Are you sensitive or allergic to any medication or anesthetics? ……..YES NO
   a. If yes, please list: _____
6. Indicate which of the following you have had or have at present. Circle "yes or no" to each item.

Allergy to Latex	YES	NO	Kidney trouble	YES	NO	Hepatitis C	YES	NO
Allergy to Metal	YES	NO	Ulcers …….	YES	NO	Venereal Disease	YES	NO
Heart Failure	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Disease or Attack	YES	NO	Thyroid Problems…	YES	NO	H.I.V. Positive	YES	NO
Chest Pain	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Heart Murmur	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
High Blood Pressure	YES	NO	Radiation	YES	NO	Hemophilia	YES	NO
Arteriosclerosis	YES	NO	Chemotherapy	YES	NO	Anemia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Sickle Cell Disease	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Bruise Easily	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Epilepsy or Seizures	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Fainting or Dizzy Spells	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Nervousness	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Tumors	YES	NO
Rheumatism	YES	NO	Hepatitis A (infectious)	YES	NO	Sinus Trouble	YES	NO
Drug Addiction	YES	NO	Liver Disease	YES	NO	Developmentally Disabled	YES	NO
Stroke	YES	NO	Yellow Jaundice	YES	NO	Do you Smoke	YES	NO
Artificial Joints (hip, knee)	YES	NO	Hepatitis B (serum)	YES	NO			

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired: ……YES NO
8. Do your ankles swell during the day?.....YES NO
9. Do you use more than two (2) pillows to sleep?.....YES NO
10. Have you lost or gained more than 10 pounds in the past year?.....YES NO
11. Do you ever wake up from sleep and feel short of breath?.....YES NO
12. Are you on a special diet?.....YES NO
13. Do you have or have you had any disease, condition or problem not listed?.....YES NO
    a. If yes, please list:_____

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.

Patient Signature _____ Date_____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to patient _____

FOR OFFICE USE ONLY: Reviewed by Dr._____ Date _____

DENTAL HISTORY

Chief complaint (if any) or purpose of this appointment: _____
_____.

Date of last dental visit: _____
Date of last dental cleaning: _____
Date of last full-mouth series of x-rays: _____
Name of previous dentist: _____

	Yes	No
Do you think you have any decayed teeth?	___	___
Are any of your teeth sensitive to: cold? sweets? heat? pressure?	___	___
Do your gums bleed frequently?	___	___
Do you frequently have bad breath or a bad taste in your mouth?	___	___
Do you have any teeth that feel loose?	___	___
Do you suffer from frequent headaches?	___	___
Do you have face or jaw pain?	___	___
Have you ever worn braces?	___	___
Do you wear any dentures or dental appliances?	___	___
Have you ever had any teeth extracted (other than wisdom teeth)?	___	___
Do you use any herbal medicines?	___	___
Do you chew gum or eat candy regularly?	___	___
Do you use a soft? medium? or hard? toothbrush?	___	___
Does food or floss catch between your teeth?	___	___
Do any of your teeth ache?	___	___
Are there any sores or growths in your mouth?	___	___
Do you use a fluoride toothpaste?	___	___
Have you ever had an unusual reaction to dental anesthetic?	___	___
Have you ever had any complications following dental treatment?	___	___
Have you ever received a "deep cleaning" or scaling/root planning?	___	___
Have you ever been diagnosed with periodontal disease?	___	___

What do you do each day to take care of your teeth and gums? _____
_____

Does dental treatment cause you: fear? anxiety? concern? no problem?
Are you happy with the appearance of your smile? _____ If not, why? _____
_____

Comments or remarks: _____
_____
_____

Signature: _____ Date: _____

Jason C. Leroux, D.D.S. **Palm Dental Care**

225 N. Santa Rosa St
San Luis Obispo, CA 93405
(805) 543-3747 fax: (805) 543-3914
web: www.slodds.com

PATIENT FINANCIAL LIABILITY FORM

FINANCIAL RESPONSIBILITY

Please understand that full payment of your account is considered part of your treatment and is required for all services rendered. Please understand that full payment of past services rendered and treatment given is required before future services and treatment may be made. We expect full payment at the time services are rendered. This office accepts most major credit cards and Care Credit. Checks are accepted with a valid photo ID. All checks are sent to a guarantee agency. Returned checks are subject to additional service fees. Extended payment plans may be offered with PRIOR credit approval and PRIOR patient request. All unpaid accounts, or paid in part, are subject to a 1.5% late fee assessed daily on the remaining balance. Non-emergent Dental services can, and will be, denied for unpaid and/or late accounts.

INSURANCE is accepted under the following conditions: All co-payments, and coinsurance are due to Jason C. Leroux, DDS prior to treatment. **YOU,** the patient, remain responsible for payment for services if your dental plan/insurance carrier has not paid for such services after 45 days. This practice subscribes to a national service that provides the usual and customary fee(s) for our area. Unless we are a preferred provider for your dental insurance plan, **YOU,** the patient, remain responsible for payment of the fee(s) despite any insurance companies' arbitrary determination of rates.
*Please note- our office only uses composite (white) filling material and does not place amalgam (silver) fillings regardless of tooth position.
You must agree to this policy if we agree to accept your insurance as a form of payment.

Missed appointments are subject to our regular charges and/or NO SHOW FEES added to your account. This practice **DOES NOT** double-book patient appointments so that you have less wait time, and the doctor will be able to spend more time treating you. We require at least **24 hours** advance notice of cancellations for your reserved appointment time or full charges are due for a normal office visit and/or applicable **NO SHOW FEES**. We routinely call 1-2 days in advance to reconfirm appointments. Failure to reconfirm can result in the loss of your appointment.

This practice **DOES** use all legal means provided to us under law to collect bad debt accounts, including outside collection agencies, credit reporting agencies, and small claims court. These resources are outsourced from our practice and require payment. If you refuse to pay on your account and your account becomes bad debt for this practice, we will proceed in using collection agencies, and we **WILL** report your bad payment history to the top three National Credit Report Agencies. All fees charged to our practice from these agencies for the collection of payment on your account **WILL BE ADDED BACK TO YOUR ACCOUNT**. **In addition, fraudulent accounts, or patients who pass bad checks to this practice will also be turned over to a collection agency for resolution and additional fees will be assessed to the patient.**

*With your permission, we will use your cell phone number on record, to contact you regarding any financial account balance or additional insurance information needed. _____
(please initial)

"I have read the above information and agree to the terms contained therein." _____
(please initial)

_____ _____
Patient's PRINTED Name *Social Security Number*

_____ _____
Patient's Signature *Driver's License Number & State*

_____
Date

225 N. Santa Rosa St, San Luis Obispo, CA 93405
(805) 543-3747

OUR GOLDEN RULE

We are very happy you have chosen us for your dental and oral health needs. We promise to do our best to restore your smile, maintain your oral health, and educate you as to what we are doing and what you *should* be doing.

In return, we ask only **ONE** thing; keep your appointment, or cancel it with 24 hours' notice! Here's why;
Much of the high cost of dentistry has to do with the high cost of running a dental office.
We have set aside a block of time for *your* appointment. We don't overbook, but instead prefer to allot sufficient time to each patient to address his or her needs!
Many things happen prior to your appointment. Sterilized equipment is opened and an operatory is readied for your visit. The machinery and equipment runs whether you come or not. My highly trained staff eagerly awaits your arrival, and gets paid whether you show up for your appointment or not. If you don't show up, or if you cancel without sufficient notice, we *all* suffer. Somewhere, another person may be waiting in pain and is not being seen by the doctor because time was reserved for you.

For our part, we will help as much as we can. We give you an appointment card with the time and date of your next visit on it. Please transfer the information to your calendar. For hygiene appointments, we send a reminder text or phone call 5 days in advance of your visit. We also call and text to confirm one or two days prior to your appointment.

So here's the deal… **we simply ask for at least 24 hours notice**. Simply call, or if we are not available, leave a message, but do it at least **24 hours** prior to your appointment time. If you cannot provide that, we will bill you **$100 for a missed appointment**.
_____ (initial)

In exchange for following this one very important rule you will receive our undivided attention, and superb dental care from the best dental team in town!