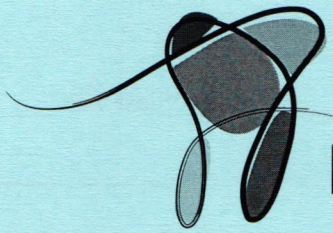

CURRIER
Dental Studio

Patient Information

Name _____
First MI Last

Preferred Name _____ ❑ Male ❑ Female Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Mobile # _____ Work # _____

Social Security # _____ DL # _____ Email Address _____

Occupation _____ Employer Name _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Spouse or parent's name _____

Person to contact in case of emergency _____ Phone # _____

Relationship to patient _____

Other family members seen by us _____

Responsible Party

Do you have dental insurance? ❑ Yes ❑ No If yes, please bring card to font desk.

Policyholder's Name _____ Birth Date _____ SS# _____

Insurance Company _____ Group # _____

Patient Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please note payment is due at time of service, including all insurance co-pays and deductibles or for cash-pay patients.

Dental History

Former Dentist _____ Date of last visit _____

Medical History

Current Physician _____ Date of last visit _____

Please list any known drug allergies _____

Have you ever taken Bisphosphonates for Osteoporosis? (Actonel, Fosamax, or Boniva) ❑ Yes ❑ No

- ❑ Pregnant
- ❑ Nursing
- ❑ Birth Control Pills
- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artifical Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back problems
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chronic Fever
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough Up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems (describe below)
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Neuropathy
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Sensory Issues
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venearal Disease
- ❑ Other (list below)

Current medications

_____
_____
_____
_____
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_____

All past hospitilizations
(Please include dates)

_____
_____
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Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such dental care, to third party payers and/or health practicioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's.

X _____ _____

SIGNATURE OF PATIENT (or parent if minor) DATE

CURRIER
Dental Studio

Megan H. Currier, D.D.S.

Consent for Services and Financial Policy:

As a condition of treatment by this office, payment is expected and due at time of service. In most cases, no financial arrangements are to be considered. For all insurance-based patients, co-pays and deductibles are to be paid in full at each visit. Please remember all quotes given are only estimates. Please understand that your dental insurance carrier may pay less than the actual bill for services. If this happens, you will receive a statement in the mail requesting additional payment due.
I am authorizing and requesting that my insurance company will pay directly to Currier Dental Studio. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Signature *Date*

HIPAA Acknowledgement:

I understand that at any time, this authorization may be revoked, when the office that receives this authorization received a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

X_____
Signature *Date*

Cancellation Policy:
Please note our cancellation policy has changed as of January 1, 2020. We know that unplanned situations may arise, and you may need to cancel your dental appointment. We ask to please allow a 24-hour notice in doing so. After three failed or last-minute cancellations we reserve the right to dismiss you as a patient. You will receive a dismissal letter via mail informing you of your patient status with us. At this point we will kindly forward all your dental records to any dental office of choice.

X_____
Signature *Date*

currierdentalstudio@gmail.com • (985) 345-1180
2102 Rue Simone • Hammond, LA 70403

CURRIER
Dental Studio

Megan H. Currier, D.D.S.

Currier Dental Studio

Name: _____

Date: _____

Please tell us how you learned about our practice. (Please select all that apply).

_____ Patient Referral Name: _____

_____ Staff Referral Name: _____

_____ Dentist/Doctor Referral Name: _____

_____ Internet Search, Google, Facebook, Instagram, etc.

_____ Tangi Lifestyles Magazine

_____ North Cypress Fitness

_____ Daily Star Newspaper Edition

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