

Patient Information

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed Child

Birth Date: _____ Age: _____ Social Security #: _____

Email: _____

Employer: _____ Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Preferred Dentist: _____ Preferred Hygienist: _____

Preferred Pharmacy: _____ Phone#: _____

I would like to receive correspondence via text messages

I would like to receive correspondence via email

Do you or any of your immediate family members see Dr Ouellette or Dr Beene? Yes No

If yes, who? _____

Referral Information

Name of person or Doctor referring you to our practice: _____

Responsible Party:

Patient Spouse Parent Other: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security #: _____

Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Parent Other: _____

Insured SS#: _____ Insured Date of Birth: _____

Insurance Company: _____ Employer: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone Number: _____ Phone Number: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Parent Other: _____

Insured SS#: _____ Insured Date of Birth: _____

Insurance Company: _____ Employer: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone Number: _____ Phone Number: _____

Dr David Ouellette, DDS
Dr Tad Beene, DDS

**NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

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

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

I have received, read, and understand you NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand Dr David Ouellette, DDS & Dr Tad Beene, DDS had the right to change its NOTICE OF PRIVACY PRACTICES from time to time. I may contact the Office Manager at any time at 501-847-7999 to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand 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: _____

Witness Signature: _____ Date: _____

Office Use Only

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Important dental insurance and financial information for our patients

We know understanding your dental insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients with many different insurance companies. Each employer pays an insurance premium for specific coverage, which fits into the company budget. Each plan is slightly different in its covered services. **We encourage you to become familiar with your policy exclusions, deductibles, maximum, anniversary date, and required co-payments. There are thousands of dental plans & we are not responsible for knowing the details of your particular plan.**

To help achieve this goal, we need your assistance and your understanding of our payment policy:

- Payment for services is due at the time services are rendered, unless our staff has approved payment arrangements in advance.
- We accept cash, check, MasterCard, Visa, American Express, & Discover.
- We also offer Care Credit and Dental Fee Plan financing.
- Returned checks and balances over 30 days old are subject to Finance Charges
- Charges may also be made for broken appointments canceled without 24 hours advance notice.

Please realize about your Dental Insurance:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party in the contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- Our fees are generally considered to fall with the UCR range. "UCR" is defined as usual, customary and reasonable charges. All restrictions are based on your employers' plan & the premium paid for the insurance---not on our fees or recommended treatment.

Thank you for your cooperation with your dental insurance coverage. Please sign below & have your insurance card ready for us to copy for our file.

Insurance:

I authorize release of any information concerning my (or my child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize payment of insurance benefits directly to Dr David Ouellette, DDS or Dr Tad Beene, DDS otherwise payable to me.

I am aware no insurance company attempts to cover all dental costs and the agreement of the insurance company to pay for my dental care is a contract between me and the insurance company.

I understand the staff at Dr David Ouellette, DDS's office will file my insurance for me and my benefits are only **ESTIMATED**. If my dental insurance company does not respond to the submitted claim within 60 days, I understand I may be responsible for the balance in full (all estimated insurance payments as well as my estimated amount due).

Signature (parent/guardian, if minor)

Date

Fees & Payments:

I agree to be responsible for this account. All balances are due in full unless other payment arrangements have been made. If I am unable to pay my account, I will inform the business office before treatment and will make definite payment arrangements. All accounts 31 days old will be billed a fiancé charge in accordance with Arkansas law. Any accounts without payment made with in 60 days will be considered for collection by an outside collection agency. Should this office refer my account to the outside collection agency, I agree to pay a collection fee and any unpaid balance.

Signature (parent/guardian, if minor)

Date

Patient Dental History

Name of Previous Dentist & Location _____ Date of Last Exam _____

Please consider each statement carefully. Dr Ouellette & members of his dental team will discuss each of your responses with you in confidence.

	Yes	No		Yes	No
Do your gums bleed when brushing or flossing?	<input type="radio"/>	<input type="radio"/>	Do you grind or clench your teeth?	<input type="radio"/>	<input type="radio"/>
Are your teeth sensitive to hot or cold liquids/foods?	<input type="radio"/>	<input type="radio"/>	Do you bite your lips or cheeks frequently?	<input type="radio"/>	<input type="radio"/>
Are your teeth sensitive to sweet or sour liquids/foods?	<input type="radio"/>	<input type="radio"/>	Have you ever had any difficult extractions in the past?	<input type="radio"/>	<input type="radio"/>
Do you feel pain in any of your teeth?	<input type="radio"/>	<input type="radio"/>	Have you ever had prolonged bleeding?	<input type="radio"/>	<input type="radio"/>
Do you have any sores or lumps in your mouth?	<input type="radio"/>	<input type="radio"/>	Have you had any orthodontic treatment?	<input type="radio"/>	<input type="radio"/>
Have you ever had any head, neck or jaw injuries?	<input type="radio"/>	<input type="radio"/>	Do you wear dentures or partials?	<input type="radio"/>	<input type="radio"/>
Have you ever experienced any of the following problems with your jaw?	<input type="radio"/>	<input type="radio"/>	If yes, date of placement: _____		
Clinching	<input type="radio"/>	<input type="radio"/>	Have you ever received oral hygiene instructions regarding the care of your teeth?	<input type="radio"/>	<input type="radio"/>
Pain (join, ear, side of face)	<input type="radio"/>	<input type="radio"/>	Do you like your smile?	<input type="radio"/>	<input type="radio"/>
Difficulty in opening or closing	<input type="radio"/>	<input type="radio"/>			
Difficulty in chewing	<input type="radio"/>	<input type="radio"/>			
Do you have frequent headaches?	<input type="radio"/>	<input type="radio"/>			
Do you grind or clench your teeth ?	<input type="radio"/>	<input type="radio"/>			

	Yes	No
I am concerned about the appearance of my teeth or my smile.	<input type="radio"/>	<input type="radio"/>
I am concerned about the lack of whiteness of one or more of my teeth.	<input type="radio"/>	<input type="radio"/>
I am concerned about the position or angle of one or more of my teeth.	<input type="radio"/>	<input type="radio"/>
I am concerned about the shape of one or more of my teeth.	<input type="radio"/>	<input type="radio"/>
In social situations, my teeth or my smile embarrasses me.	<input type="radio"/>	<input type="radio"/>
There are some things about my upper front teeth I would like to change.	<input type="radio"/>	<input type="radio"/>
There are some things about my lower front teeth I would like to change.	<input type="radio"/>	<input type="radio"/>
I have old fillings or previous dental work that is no longer satisfactory to me.	<input type="radio"/>	<input type="radio"/>
My bite is sometimes uncomfortable when chewing or biting.	<input type="radio"/>	<input type="radio"/>
I am interested in learning more about cosmetic dentistry.	<input type="radio"/>	<input type="radio"/>
Have you ever had a bad experience in the dental office?	<input type="radio"/>	<input type="radio"/>
Please Explain: _____		

Authorization & Release	
I certify that I have read and understood 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 & the records of any treatment or examination rendered to my child or me during the period of dental care to third party payers and/pr health practitioners.	
_____ Signature of patient, parent or guardian	_____ Date

Patient Medical History

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems you may have or medication you are taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?

Yes No If yes, please explain: _____

Have you been hospitalized or had a recent operation in the last 12 months?

Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury?

Yes No If yes, please explain: _____

Are you taking any medication, pills, or drugs?

Yes No If yes, please explain: _____

Do you take or have you taken Phen-Fen or Redux?

Yes No When? _____

Are you on a special diet?

Yes No If yes, please explain: _____

Do you use tobacco?

Yes No If yes, how often: _____

Do you use controlled substances?

Yes No If yes, please explain: _____

WOMEN

Are you: Pregnant/Trying to get pregnant? Nursing Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local anesthetics

Other _____

Do you have or have you had any of the following?

- | | | | | |
|--|---|---|---|---|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Chest Pains | <input type="radio"/> Frequent Headaches | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Cold Sores/fever Blisters | <input type="radio"/> Genital Herpes | <input type="radio"/> Kidney Problems | <input type="radio"/> Shingles |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Glaucoma | <input type="radio"/> Leukemia | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Convulsions | <input type="radio"/> Hay Fever | <input type="radio"/> Liver Disease | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Angina | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Diabetes | <input type="radio"/> Heart Murmur | <input type="radio"/> Lung Disease | <input type="radio"/> Stomach Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Drug Addiction | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Easily Winded | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Pain Jaw Joints | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Asthma | <input type="radio"/> Emphysema | <input type="radio"/> Hemophilia | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Blood Disease | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hepatitis A | <input type="radio"/> Psychiatric Care | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Radiation Treatment | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Excessive Thirst | <input type="radio"/> Herpes | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Tumors/Growths |
| <input type="radio"/> Bruise Easy | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> High Blood Pressure | <input type="radio"/> Renal Dialysis | <input type="radio"/> Ulcers |
| <input type="radio"/> Cancer | <input type="radio"/> Frequent Cough | <input type="radio"/> Hives or Rash | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Hypoglycemia | <input type="radio"/> Rheumatism | <input type="radio"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No

If Yes, please explain: _____

Additional Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of patient, parent or guardian

Date