

Walton Dental Care
862 Michael Etchison Rd.
Monroe, GA 30655

Welcome to our practice! We are excited to be your dental health team and we look forward to taking great care of you! Please take a few moments to share your dental and medical history with us- it is important for us to have this information so that we can help you achieve optimal dental health. We are always happy to answer any questions you may have.

It is our goal to see you promptly at your scheduled time. In the event you are unable to keep a scheduled appointment, kindly give at least 24 hours' notice.

Payment is due when services are rendered. We accept cash, checks, Visa, Mastercard, Discover, Amex and Care Credit. Please ask about the options we offer with Care Credit.

For patients with dental insurance, we are a fee-for-service practice. We are not a contracted provider. As a courtesy, our team will be happy to file your dental claim if you have provided all the necessary information for filing. You will be responsible for the total fee for services provided. Your plan will participate in your care based on your policy plan and provisions.

Regarding minors, the parent requesting services for a minor child is financially responsible for those services provided.

We are not a Medicare or Medicaid provider. Medicaid will not cover any services provided in our office.

For patients with a Medicare dental benefit, we are unable to file claims for you. We are happy to provide you with a paid receipt for you to submit to your Medicare provider.

FEMALE PATIENTS- Before each visit, please inform us if you are pregnant or may possibly be pregnant before any treatment begins, including x-rays, anesthesia, or nitrous oxide (gas).

Our Notice of Privacy Practices is posted on our website for your review prior to completing your patient forms. Printed copies are available in our office.

I have read and understand these office policies. I acknowledge that any questions I have about the above have been answered to my satisfaction. I, the undersigned patient, or legally responsible party, authorize treatment to be rendered and assume full financial responsibility. I acknowledge any balance remaining on my account will be paid in full promptly upon receipt of a billing statement or notice from the office. I acknowledge that all accounts over sixty (60) days old will be charged a service fee of 1.5% per month (18% annually) on the unpaid balance. Any collection and or attorney fees incurred to collect this account will be borne by the account.

Patient or Guarantor Name (please print) _____

Patient or Guarantor Signature _____ Date _____

Whom may we thank for referring you to our office _____

FINANCIAL INFORMATION

Financial Responsibility:

Last Name _____ First Name _____ MI _____

Date of birth _____ SS# _____ Male Female

Married Single Other Child

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Employer _____ Address _____

May we contact you by email? Yes No Email _____

May we contact you by text? Yes No Cell _____

Spouse's Name _____ Date of Birth _____ Cell _____

Dental Insurance: We do not file Medicare Insurance.

Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Subscriber (employee name) _____ ID _____

Subscriber Employer _____ Group # _____

Subscriber SS# _____ Date of birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Complete only if you have Secondary Dental Insurance: We do not file Medicare Insurance.

Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Subscriber (employee name) _____ ID _____

Subscriber Employer _____ Group # _____

Subscriber SS# _____ Date of birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Assignment and Release:

I certify that I, and or my dependents, have dental insurance with the information I have provided. This information may have been provided by phone. I assign directly to Dr. Kevin M. Lacour all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of any insurance benefits. I authorize the use of this signature on all insurance submissions. The above-named dentist and his associates may use my health care information and may disclose such information to the provided insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature Patient/Responsible Party _____ Date _____

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

| | | | | | |
|---|--------------------|---------------|--|--|--|
| Name: <i>Last First Middle</i> | | | Home Phone: <i>Include area code</i> () | Business/Cell Phone: <i>Include area code</i> () | |
| Address: <i>Mailing address</i> | | | City: | State: | Zip: |
| Occupation: | Height: | Weight: | Date of Birth: | Sex: M F | |
| SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: <i>Include area code</i> () | Cell Phone: <i>Include area code</i> () | |
| If you are completing this form for another person, what is your relationship to that person? | | | | | |
| <i>Your Name</i> | | | <i>Relationship</i> | | |
| Do you have any of the following diseases or problems: | | | <i>(Check DK if you Don't Know the answer to the the question)</i> | | Yes No DK |
| Active Tuberculosis..... | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Persistent cough greater than a 3 week duration..... | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Cough that produces blood..... | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Been exposed to anyone with tuberculosis..... | | | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| If you answer yes to any of the 4 items above, please stop and return this form to the receptionist. | | | | | |

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

| Yes No DK | Yes No DK |
|--|---|
| Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Date of your last dental exam: |
| If yes, how often? <i>Circle one:</i> DAILY / WEEKLY / OCCASIONALLY | What was done at that time? |
| Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Date of last dental x-rays: |
| What is the reason for your dental visit today? | |
| How do you feel about your smile? | |

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| Yes No DK | Yes No DK |
|--|---|
| Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Physician Name: _____ Phone: <i>Include area code</i> () | If yes, what was the illness or problem? |
| Address/City/State/Zip: | Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: |
| Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ |
| If yes, what condition is being treated? | _____ |
| Date of last physical exam: | _____ |

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | |
|---|---|
| <p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p> | <p style="text-align: right;">Yes No DK</p> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? <i>Circle one: VERY / SOMEWHAT / NOT INTERESTED</i></p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|---|---|

| | |
|--|---|
| <p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

| | | |
|--|---|--|
| <p style="text-align: right;">Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|--|

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

| | |
|---|---|
| <p style="text-align: right;">Yes No DK</p> <p>Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: right;">Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> |
|---|---|

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: *Include area code*
()

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Snore Questionnaire:

| | YES | NO |
|--|--------------------------|--------------------------|
| Have you ever been told that you snore | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a sleep study or been told to have a sleep study | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been diagnosed with sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear a C-PAP or have you been told to wear one | <input type="checkbox"/> | <input type="checkbox"/> |

If you have had a sleep study or been diagnosed with sleep apnea, please provide the following information:

Date of Study _____

Medical Facility and Provider of the study _____

I ACKNOWLEDGE THAT I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT PROVIDING INCORRECT OR INACCURATE INFORMATION MAY BE DETRIMENTAL TO MY HEALTH.

PRINT: PATIENT/PARENT/GUARANTOR NAME _____

SIGNATURE: PATIENT/PARENT/GUARANTOR _____

DATE: _____

HIPAA Authorization to release protected information.

Please Print

I, (patient name) _____ authorize the following person(s) to have access to my personal information covered under the HIPAA Privacy Act. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

| NAME | RELATIONSHIP |
|----------|--------------|
| 1) _____ | _____ |
| 2) _____ | _____ |
| 3) _____ | _____ |

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at Walton Dental Care, 862 Michael Etchison Rd., Monroe, GA 30655.

If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

Patient Signature _____ Date _____

HIPAA ACKNOWLEDGEMENT

*** You may refuse to sign this acknowledgement ***

I have reviewed a copy of this office's Notice of Privacy Practices or have requested a written copy.

Print Name _____

Signature _____

Date _____

*** For Office use Only ***

Individual refused to sign Communication barriers Emergency prohibited obtaining the acknowledgement