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 ___________

American Dental Association
www.ada.org

Child Health/Dental History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____________
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician ____ Phone ____________________

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? .... 1. If yes, please list: ____________	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ____________ 2.	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: ____________ 3.	❑	❑
4.	How would you describe the child's eating habits? ____________		
5.	Has the child ever had a serious illness? If yes, when: ________ Please describe: ____________ 5.	❑	❑
6.	Has the child ever been hospitalized? .... 6.	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: ____________ 7.	❑	❑
8.	Has the child ever received a general anesthetic? .... 8.	❑	❑
9.	Does the child have any inherited problems? .... 9.	❑	❑
10.	Does the child have any speech difficulties? .... 10.	❑	❑
11.	Has the child ever had a blood transfusion? .... 11.	❑	❑
12.	Is the child physically, mentally, or emotionally impaired? .... 12.	❑	❑
13.	Does the child experience excessive bleeding when cut? .... 13.	❑	❑
14.	Is the child currently being treated for any illnesses? .... 14.	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ________ 15.	❑	❑
16.	Has the child had any problem with dental treatment in the past? .... 16.	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed? .... 17.	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth? .... 18.	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth? .... 19.	❑	❑
20.	Has the child had any orthodontic treatment? .... 20.	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?** .... 22.	❑	❑
23.	**Is fluoride toothpaste used?** .... 23.	❑	❑
24.	How many times are the child's teeth brushed per day? ________ When are the teeth brushed? ____________ 24.	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier? .... 25.	❑	❑
26.	At what age did the child stop bottle feeding? Age ________ Breast feeding? Age ________		
27.	Does child participate in active recreational activities? .... 27.	❑	❑

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. 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.

Parent's/Guardian's Signature ____________________________________ Date ____________________

For completion by dentist

Comments ____

____

____

____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by____________________

Date ____

© American Dental Association, 2006
Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

WALTON DENTAL CARE
862 Michael Etchison Rd.
Monroe, GA 30655

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