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

ADA American Dental Association®
America's leading advocate for oral health

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: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

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
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

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? ☐ ☐ ☐

Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics _____ ☐ ☐ ☐
Aspirin _____ ☐ ☐ ☐
Penicillin or other antibiotics _____ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills _____ ☐ ☐ ☐
Sulfa drugs _____ ☐ ☐ ☐
Codeine or other narcotics _____ ☐ ☐ ☐

Yes No DK

Metals _____ ☐ ☐ ☐
Latex (rubber) _____ ☐ ☐ ☐
Iodine _____ ☐ ☐ ☐
Hay fever/seasonal _____ ☐ ☐ ☐
Animals _____ ☐ ☐ ☐
Food _____ ☐ ☐ ☐
Other _____ ☐ ☐ ☐

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

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Damaged valves in transplanted heart ☐ ☐ ☐
Congenital heart disease (CHD)
- Unrepaired, cyanotic CHD ☐ ☐ ☐
- Repaired (completely) in last 6 months ☐ ☐ ☐
- Repaired CHD with residual defects ☐ ☐ ☐

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

Yes No DK

Cardiovascular disease ☐ ☐ ☐
Angina ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur ☐ ☐ ☐
Low blood pressure ☐ ☐ ☐
High blood pressure ☐ ☐ ☐
Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐
Pacemaker ☐ ☐ ☐
Rheumatic fever ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Abnormal bleeding ☐ ☐ ☐
Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
If yes, date: _____
Hemophilia ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐
Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Systemic lupus erythematosus ☐ ☐ ☐
Asthma ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐
Chest pain upon exertion ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes Type I or II ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/persistent heartburn ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐
Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐
Hepatitis, jaundice or liver disease ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Fainting spells or seizures ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
If yes, specify: _____
Sleep disorder ☐ ☐ ☐
Do you snore? ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Specify: _____
Recurrent Infections ☐ ☐ ☐
Type of infection: _____
Kidney problems ☐ ☐ ☐
Night sweats ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Persistent swollen glands in neck ☐ ☐ ☐
Severe headaches/ migraines ☐ ☐ ☐
Severe or rapid weight loss ☐ ☐ ☐
Sexually transmitted disease ☐ ☐ ☐
Excessive urination ☐ ☐ ☐

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	☐	☐
Have you ever had a sleep study or been told to have a sleep study	☐	☐
Have you ever been diagnosed with sleep apnea	☐	☐
Do you wear a C-PAP or have you been told to wear one	☐	☐

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: _____

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

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 *

We attempted to obtain written acknowledgement of receipt of our office Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Emergency prohibited obtaining the acknowledgement

☐ Communication barriers ☐Other (please specify) _____