

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 _____

Child Health/Dental History Form



American Dental Association
www.ada.org

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 <input type="checkbox"/> F <input type="checkbox"/>	
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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:				
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sick cell
<input type="checkbox"/> Thyroid				
<input type="checkbox"/> Tobacco/Drug Use				
<input type="checkbox"/> Tuberculosis				
<input type="checkbox"/> Venereal Disease				
<input type="checkbox"/> Other _____				
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? If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
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. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14. <input type="checkbox"/>	<input type="checkbox"/>
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. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. Does the child take fluoride supplements?	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities?	27. <input type="checkbox"/>	<input type="checkbox"/>

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 _____

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 *

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) _____