Geaux Smiles
406 Lafayette St.
Gretna, LA 70053
(P) (504) 366-3052
(F) (504) 366-9201

New Patient Registration Checklist

Thank you for taking time to visit our website and for downloading our new patient packet. In order for your appointment to begin on time, please review the following checklist and bring each of the items listed on it with you to your appointment. If you need directions to our office, you can visit our website or call us directly. We are happy to help!

- ✓ Picture ID (driver's license or other government issued identification card with photograph).
- ✓ Dental Insurance Card (without this card, we will not be able to file your insurance claim).
- ✓ Completed New Patient Registration Form (please file out ALL applicable portions including social number and date of birth).
- ✓ Completed and Signed Medical History Form (please be thorough).
- ✓ Signed HIPPA form.
- ✓ Signed Office Policy form (if minor, signature needs to be by the person who is financially responsible for patient).
- ✓ Signed General Consent form
- ✓ A form of payment (we accept all major credit card as well as personal checks and cash).

We look forward to meeting you soon! If you have any questions regarding your new patient paperwork or have questions about anything else regarding your appointment or your dental care, don't hesitate to call our office. If you find that you cannot arrive for your appointment on time, please make sure to give our office at least 48 hour notice.

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New Patient Registration

Date: ____

Name: ____ Nickname: _______________________

Address: __________________________________City: ______________State: ________ Zip: ___________

Home (______)________________ Work (______)________________ Cell (______)_________________

Date of Birth: _______/_______/_______ Social Security Number: ___________-________-_____________

Status: ☐ Minor ☐ Single ☐ Married ☐Widowed ☐ Separated ☐Divorced

Whom may we thank for referring you to us? ☐ Phone Book ☐ Website ☐ Facebook ☐ Twitter ☐ Instagram

☐ Google ☐ DemandForce ☐ Insurance ☐ Signage ☐ Other ________________ ☐ Individual___________

Email Address: ____

Would you like to receive emails from our office for appointment reminders, personalize recall, newsletters, promotions and survey? ☐ Yes ☐ No

Emergency Contact

Emergency contact: _____________________________________ Relationship: _______________________

Home (______)________________ Work (______)________________ Cell (______)_________________

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _______________

Name: ____

Address: __________________________________City: ______________State: ____ Zip: _______________

Home (______)________________ Work (______)________________ Cell (______)_________________

Employer: ____

Social Security Number: ___________-________-____

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Insurance Information

INSURED:

Name: ____

Date of Birth: _______/_______/_______ Social Security Number: ___________-________-____________

Relationship to Patient: Self Spouse Parent Other: ______________________________

Home (______)________________ Work (______)________________ Cell (______)_________________

EMPLOYER:

Name: ____

Address: __________________________________City: ______________State: ____ Zip: _______________

Work (______)____

PRIMARY INSURANCE COMPANY

Insurance Company: ____

Group Number: _______________________________ ID Number: __________________________________

Address: __________________________________City: ______________State: ____ Zip: _______________

Work (______)____

SECONDARY INSURANCE COMPANY

Insurance Company: ____

Group Number: _______________________________ ID Number: __________________________________

Address: __________________________________City: ______________State: ____ Zip: _______________

Work (______)____

GEAUXSMILES
HUNG HOANG DDS AND ASSOCIATES

Geaux Smiles
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Medical History

Patient Information

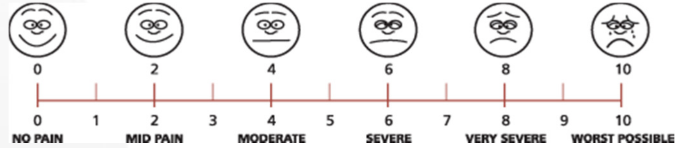
Name: ____ Date of Birth: _______/_______/_______

Dental History

Previous Dentist: _______________________________________ Last Visit: _______/_______/_______

Currently experiencing pain? Yes No

If yes, indicate pain level: _____



	Yes	No	Unsure
Do you bleed excessively after tooth extractions?			
Have you had pain or swelling for more than two weeks after surgery to the jaw?			
Any serious reactions to local/general anesthetics, nitrous oxide?			
Have you ever had serious trouble associate with any previous dental treatment?			
Do you have any soft tissue sores or bumps in your mouth?			
Do you clench or grind your teeth?			
Are any teeth sensitive to cold or sweets?			
Has a doctor told you to take antibiotics BEFORE having dental treatment?			

Medical History

	Yes	No	Unsure
Are you being treated by a medical doctor now?			
Reason: Physician's Name:			
Are you taking any medications at the present time?			
List:			
Have you ever taken medication to relieve anxiety or depression?			
Sensitive or allergic to any medication or to latex gloves/products?			
Have you ever been hospitalized or had any surgical operations?			
Ever had excessive bleeding from a cut or wound?			
Have you ever had cancer? If yes, what kind?			
Do you have pain in the chest upon exertion?			
Shortness of breath after mild exercise or exertion?			
Do your ankles swell or do you bruise easily?			
Use extra pillows to help you breathe better while sleeping?			
Do you have to urinate frequently?			
Are you thirsty and/or hungry much of the time?			
Have you lost or gained weight in the last year? Reason:			
Has a doctor ever said you had infectious diseases (ex: HIV, hepatitis C)			
Do you have difficulty with swallowing, breathing, or snoring?			
Do you have frequent infections?			
Do you have frequent headaches or migraines?			
Do you currently or have you in the past used tobacco products/alcohol?			

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Cardiovascular

	Yes	No	Unsure
Heart failure			
Heart attack or disease			
Angina Pectoris or chest pains			
Acute coronary syndrome			
High blood pressure			
Heart murmur			
Mitral valve prolapsed			
Rheumatic fever			
Congenital heart defect or lesion			
Irregular heart beat			
Heart pacemaker or defibrillator			
Heart surgery or transplant			
Other heart problems			
Stroke			
Aneurysm			

Blood/Oncology

	Yes	No	Unsure
Blood transfusion			
Anemia			
Sickle cell disease			
Leukemia			
Clotting disorder or hemophilia			
Tendency to bleed longer than normal			
Chemotherapy			
Radiation treatment			

Endocrine

	Yes	No	Unsure
Diabetes			
Thyroid disease			
Steroid therapy			

Neural/Psychiatric

	Yes	No	Unsure
Eye pain			
Vision problems			
Glaucoma			
Earaches/ringing in ears			
Hearing loss			
Severe headaches			
Fainting or dizzy spells			
Epilepsy, seizures, or convulsions			
Nervousness			
Psychiatric treatment			
Depression			
Schizophrenia			
Bipolar			
Alcohol or substance abuse			

Gastrointestinal

	Yes	No	Unsure
Gastritis/ulcers/reflux disease			
Ulcerative colitis			
Crohn's disease			
Persistent diarrhea/constipation			
Hepatitis			
Liver disease			
Yellow jaundice			
Cirrhosis			

Respiratory

	Yes	No	Unsure
Chronic bronchitis			
Emphysema			
Asthma			
Respiratory allergies			
Chronic cough			
Sinus trouble			
Tuberculosis (TB)			
Breathing difficulties			
Flu-like symptoms			

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Skin/Mucosa/Musculoskeletal

	Yes	No	Unsure
Allergy to latex (rubber gloves)			
Skin rash			
Dark mole(s) or recent changes			
Melanoma			
Fibromyalgia			
Sore muscles			
Stiff joints			
Arthritis or gout			
Artificial joint			
Osteoporosis			
Medicines for osteoporosis/bone cancer			
Intravenous (IV) bisphosphonates			

Genitourinary

	Yes	No	Unsure
Sexually transmitted disease (STD)			
Kidney(renal) dialysis			
Kidney/bladder problems			
Urinate frequently			

Oral Medicine/Facial Pain

	Yes	No	Unsure
Mouth ulcers or fungus (candidiasis)			
White/red patches in the mouth			
Dry mouth or burning tongue			
Pain in facial muscles			
TMJ problems			
Nerve pain			
Autoimmune disorders			

Other Conditions

	Yes	No	Unsure
Enlarged lymph node or gland			
Head and neck cancer			
Hyperbaric oxygen therapy			
Organ or cell transplant			
Disease, problems, or condition not listed			
List:			

Females

	Yes	No	Unsure
Are you pregnant?			
Do you plan to become pregnant soon?			
Did you have any complications during pregnancy?			
Do you have trouble with your period?			

To the best of my knowledge all the answers on all pages are true and correct. If I have a change in my health information, I will inform my dentist at my next appointment.

_________________________________ _________________________________

Signature of Patient or Guardian Date

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HIPPA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Geaux Smiles ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Geaux Smiles' Privacy Official at:

Geaux Smiles
406 Lafayette Street
Gretna, Louisiana 70053
Phone: (504) 366-3052
Fax: (504) 366-9201
Email: Info@geauxsmiles.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on September 1, 2014.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

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2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

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8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is September 1, 2014.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

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Office Policies

1. **WE REQUIRE 24 HOUR NOTICE FOR CANCELLATIONS**

   We have scheduled your appointment for you alone. We do not double book appointments. Therefore, a broken appointment fee of $25 will be charged without a 24 hour notice. We understand that there are unforeseen circumstances such as flat tire, illness, etc. that cannot be avoided in which there would not be a charge.

2. **PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT**

   If you have dental insurance, you will be expected to pay the estimated co-payment at the time of treatment. Full payment is required of emergency and walk-in patients before treatment is rendered.

3. **NSF CHECKS**

   NSF checks returned to us will automatically mean a charge to the patient account of $25. The patient will be responsible to replace the amount of the check in addition to the $25 Non-Sufficient Funds amount.

4. **WE PREPARE INSURANCE FORMS AS A COURTSEY TO YOU**

   You are responsible for necessary insurance forms and for payment of all estimated co-payments at the time of service. Remember that payment of all fees is the responsibility of the patient or person responsible for the account.

5. **INSURANCE CO-PAYMENT ARE ESTIMATES**

   Estimated co-payments are not guarantee of insurance payment. Depending of the actual insurance benefit, you may be responsible for the more or less of the fees.

6. **LET US KNOW OF ANY INSURANCE CHANGES**

7. **DEFAULT IN PAYMENT**

   All collection fees, attorney fee, court cost and any other expenses will be paid by the undersigned if there is any default in payment of this account.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES. I GUARANTEE PAYMENT OF ALL CHARGES INCURRED AS A PATIENT OF GEAUX SMILES.

__________________________________	__________________________________
Signature	Date

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General Consent

Acknowledgement

I, ___________________________, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover. All balance over 90 days, will be sent to collections.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I will show up on time for my appointments. Any cancellations will be made at least 24 hours prior to my appointment. Failure to notify the office of cancellations at least 24 hours before the appointment or not showing up to the appointment may be subject to a charge of $25 or denial of future appointments.

7. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

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8. I understand that there are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedication prior to dental care being rendered. Some of these risks/complications are, but not limited to, the following:
   - Infection, inflammation, swelling, sensitivity, and/or pain
   - Bleeding
   - Failure of wound to heal
   - Injuries to adjacent teeth and/or hard or soft tissues
   - Paresthesia or numbness of: tongue, and/or mouth, and/or face
   - Fracture of mandible (lower jaw) or maxilla (upper jaw)
   - Opening between mouth and sinus or mouth and nose
   - Tooth or fragment in maxillary sinus
   - Incomplete removal of tooth
   - Dry socket
   - Loss of teeth
   - Loss of bone
   - Slough (unanticipated loss of hard and/or soft tissue)
   - Injury to adjacent structures
   - Instrument breakage
   - Breakage of root(s) and retained root fragments
   - Swallowing and/or aspirations of objects
   - Allergic reactions to drugs
   - Trismus (jaw pain or difficulty opening mouth)
   - Failure of treatment to accomplish its purpose
   - Death (in rare instances)
   - Bacterial Endocarditis
   - Changes in bite or difficulty in opening because of stress on jaw joint (TMJ)
   - Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

_________________________________ _________________________________
Signature Date