



# Patient Information

Andre Bruni, DDS & Associates  
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## Please Print

Chart Number \_\_\_\_\_

Circle one: Dr/Mr/Mrs/Ms/Miss

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Jr/Sr: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: (circle) **M** **F** Status: (circle) **Single** **Married**

Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

How did you hear about us? **(Circle One)** Yellow Pages Bayou Pages YellowBook  
 Mailer-Newspaper Mailer-Brochure Referral Card Other: \_\_\_\_\_

Internet (if so, please circle one): Google MSN Bing Yahoo

What word did you search for? \_\_\_\_\_ What day did you search? \_\_\_\_\_

## Insurance Information

Do you have Dental Insurance? (circle) **Yes** **No**

Do you have secondary Dental Insurance? (circle) **Yes** **No**

Primary Insured		Secondary Insured	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	Self Spouse Child Other	Relationship to Subscriber	Self Spouse Child Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

\*Please present card to receptionist to be photocopied



# Health Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name & Phone #: \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_ If wearing dentures, age of dentures: \_\_\_\_\_

What treatment would you like to have completed? \_\_\_\_\_

Have you ever had any of the following dental treatment:	Y	N		Y	N		Y	N
Extraction/Date _____			Crowns/Bridges			Cosmetic Whitening		
Root Canal/Endodontics			Partial Dentures			Veneers		
Fillings			Complete Dentures			Orthodontics		
Gum/Periodontal Surgery			Implants			Other _____		

For any existing crowns, bridges, partials, or dentures? How old? \_\_\_\_\_

I brush \_\_\_\_\_ times a day.

I floss \_\_\_\_\_ times a day.

How often do you visit the dentist? \_\_\_\_\_

Do you have a history of:	Y	N		Y	N		Y	N
Epilepsy/Seizures/Date _____			Psychiatric Disorder			Joint Replacement		
Chemical Dependency			Recurrent Bronchitis			Stomach/Intestinal Disease		
High Blood Pressure			Pneumonia			Skin Disorders		
Heart surgery/Date _____			Tuberculosis			Diabetes		
Heart Attach/Date _____			Hepatitis (type A, B, C)			Anemia/Hemophilia		
Stroke/Date _____			Kidney Failure			Venereal Disease		
Chest Pains/Angina			HIV/AIDS			Asthma		
Congenital Heart Disease			Kidney Stones			Cancer		
Thyroid			Osteoporosis			Mitral Valve Prolapse		
Other _____								

Are you ALLERGIC to: \_\_\_ Penicillin? \_\_\_ Aspirin? \_\_\_ Codeine? \_\_\_ Latex? \_\_\_ Other? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Packs per day? \_\_\_\_\_

Do you use alcoholic beverages? \_\_\_\_\_ Drinks per week? \_\_\_\_\_

**LADIES ONLY:** Are you pregnant? \_\_\_\_\_ If so, what month? \_\_\_\_\_

**List all medications you are currently taking:**

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## Privacy Agreement

Dr. Andre Bruni, Associates and Staff (hereinafter collectively referred to as “We” and “Dentist”) agree to maintain the privacy of their patients as outlined in this HIPAA form. We take great care in being able to extend a higher level of privacy than is required by HIPAA, state confidentiality law and common law.

Due to the complex nature of State and Federal Privacy laws it has come to our attention that some dental offices are able to work around these laws. An example: Under HIPAA a dentist is not allowed to receive money for selling patient lists or protected health information to companies to market their products or services directly to patients without authorization. It is our understanding that there are dental practices that lawfully circumvent this limitation by allowing a third party to market the information. It is important to note that personal data is not in the possession of the company selling its products or services, but the patient may still receive unwanted solicitation. We do not agree with this manner of marketing and furthermore, we do not think it is in our patients’ best interest. Therefore, we agree not to provide any list for marketing or to accept any payment for patient lists or protected health information to any third party for the purpose of marketing to our patients.

In consideration for treatment and the above additional protection of patient’s privacy, Patient agrees to refrain from directly or indirectly publishing commentary that would reasonably be considered negative to the Doctor, the practice and/or the Doctor’s Associates and Staff unless such commentary is explicitly required by law. We have invested a significant amount of resources in the development of our practice through our time, money and marketing and ask that you not defame, disparage or discuss the Doctor, the Associates, the Staff or our practice in a negative manner as it will cause serious damage to our practice.

We are adamant about our Patients’ privacy as well as the practices’ right to control its public image and privacy. Dentist and you agree to work together to prevent the publishing or broadcasting of commentary about the other party from being accessed in any media. This Agreement will be in force and enforceable for a period of the longer of (a) five years from our last date of service to Patient; or (b) three years beyond any termination of the Dentist-Patient relationship. As a matter of office policy, we are requiring all patients in our practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all our patients.

You, as the Patient, and we acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, both the Patient and Dentist agree to the right of equitable relief, including, injunctive relief and beyond. Should a breach of this Agreement result in litigation, the prevailing party in the litigation will be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive explanations to their satisfaction.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
(if under age of 18)



## New Patient Consent Forms

### ***Consent for Dental Exam, X-Rays and Treatment Planning and Acknowledgement of Receipt of Information***

State law requires us to obtain your consent for the contemplated dental exam, x-rays and treatment planning. What you are being asked to sign is confirmation you understand the nature and purpose of your visit and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct **Bluebonnet Dental Care Doctors**, assistants, hygienists, and specialists of their choice to perform upon \_\_\_\_\_ the following dental procedures:

#### **Dental exam, x-rays and treatment planning**

#### **RISK ASSOCIATED WITH THE ABOVE PROCEDURES:**

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risks known to be associated with these procedures:

Pain

Allergic reaction to latex gloves

Stretching of the mouth, which may cause bruising or result in cracking

#### **PHOTOGRAPHS:**

I hereby specifically authorize the above doctors and staff to take, develop and use photographs at all phases of my treatment for educational, demonstrative and/or promotional purposes specifically including use in lectures and publications and I do hereby forever waive any claim to royalties or other monies or other sources of reimbursement that are received from their use.

#### **ACKNOWLEDGEMENT**

I acknowledge that I have read and I understand the information contained in this consent form (or that it has been read to me).

I hereby authorize **Sensible Dental Dentist**, hygienists, specialists or assistants of their choice to perform the dental exam, x-rays and treatment planning. This Consent Form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive further disclosures or information.

Date \_\_\_\_\_ Signature of Patient \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
(if under age of 18)

Dentist \_\_\_\_\_ Witness \_\_\_\_\_

***Authorization for Dental Care on a Minor***

I authorize dental treatment to be rendered on my child/minor, \_\_\_\_\_, without my physical presence in the dental office. I have been advised that it is ideal to have a parent/legal guardian present in the office during treatment in case of any complications or medical situations that may arise. With knowledge of this, I authorize the Bluebonnet Dental Care team to take any emergency care/action or precautions deemed necessary. I still retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Doctor \_\_\_\_\_



## Financial Policy

In order to be impartial to everyone, WE REQUIRE PAYMENT AT THE TIME OF THE TREATMENT. We ask that you read and sign this statement prior to any treatment. YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF THE TREATMENT. We accept cash, checks, Visa, MasterCard, Discover Card, and American Express. For extensive treatment plans, we offer extended payment plans with CareCredit at either little or no interest with prior credit approval.

### ***ACKNOWLEDGEMENT***

I hereby certify that the medical and dental history provided is correct to the best of my knowledge and give my consent for the doctors and staff at Bluebonnet Dental Care to treat my dental needs based on this information.

### ***MISSED APPOINTMENTS***

In order to be fair to all our patients, we ask that you notify our office at least 72 hours in advance if you cannot keep your scheduled appointment. Our policy for any missed appointments is a charge of a normal office visit.

### ***REGARDING INSURANCE***

We will gladly file all dental claims for a given treatment but we are not party to any insurance programs or contracts. The balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.

I authorize Bluebonnet Dental Care to release any dental information necessary to process dental insurance claims. I also request and authorize payments of any benefits, applicable to services rendered, to Bluebonnet Dental Care.

### ***FINANCE CHARGES***

Be aware that any unpaid balance after 60 days is charged a yearly finance charge of 18% and that this finance charge is equal to 1.5% of the outstanding balance per month. If the account reaches collections status and no effort is made to pay it off, the account will be assigned to a collection attorney or agency. If the doctor must take additional steps to collect the account, all costs of collection including court costs and attorney's fees incurred by the doctor will be charged to the patient.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Approved By \_\_\_\_\_



## Aesthetic Evaluation Form

Y N

- 1. Are you self-conscious about smiling?
- 2. Do you wish your teeth were whiter?
- 3. When you look in the mirror, do you see any defects in your teeth or gums?
- 4. Do you feel you show too much gum tissue when you smile?
- 5. Do you think your teeth could be shaped more attractively?

**Please answer these questions as thoroughly as possible**

- 6. What are your goals for your teeth, mouth, and smile?
- 7. If you could change anything about your smile, what would that be?
- 8. What do you like the most about your teeth?
- 9. What do you like the least about your teeth?
- 10. What are your expectations of us?
- 11. If you had a perfect smile, what would that look like?
- 12. What exactly would prevent you from making your smile perfect?
- 13. How do you want your teeth and gums to look and feel in 20 years?
- 14. If we had something more to offer you that would improve your appearance (comfort, function) would you like to hear about it?