4500 YORK ST, STE.100
METAIRIE, LA 70001

MEKARI
DENTAL STUDIO & SPA

www.mekaridentalstudio.com
Tel: 504-888-1414

PATIENT INFORMATION

Date: ______________________ NEW PATIENT UPDATE

Patient: ______________________
LAST FIRST MI PREFERRED TITLE

MALE FEMALE CHILD* STUDENT** SINGLE MARRIED DIVORCED WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: ______________________
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: FULL-TIME PART-TIME ______________________
SCHOOL/LOCATION

Patient Date of Birth: ______________________

Address: ______________________
ADDRESS LINE 1
____
ADDRESS LINE 2
____
CITY ST ZIP CODE

E-Mail: ______________________

Patient SSN: ______________________
HOME: ______________________
CELL: ______________________
OTHER: ______________________
PAGER: ______________________
FAX: ______________________

Referral? Yes No Referred by: ______________________

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

______________________ Tel: ______________________
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: ______________________

Address: ______________________
ADDRESS LINE 1
____
ADDRESS LINE 2
____
CITY ST ZIP CODE

E-Mail: ______________________

Occupation: ______________________
WORK: ______________________
DIRECT: ______________________
OTHER: ______________________
PAGER: ______________________
FAX: ______________________

INSURANCE INFORMATION

Subscriber: ______________________
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: ______________________ Subscriber SSN: ______________________

Subscriber Employer: ______________________

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER: ______________________

Group/Policy No.: ______________________ ID No.: ______________________

Address: ______________________
____
____
CITY ST ZIP CODE

TEL: ______________________
TOLL-FREE: ______________________
FAX: ______________________

SECONDARY INSURANCE CARRIER: ______________________

Group/Policy No.: ______________________ ID No.: ______________________

Address: ______________________
____
____
CITY ST ZIP CODE

TEL: ______________________
TOLL-FREE: ______________________
FAX: ______________________

PREVIOUS DENTIST INFORMATION

Dentist: ______________________ Telephone: ______________________

Clinic/Facility: ______________________

Address: ______________________

CITY ST ZIP CODE

Reason for changing: ______________________

DENTAL HISTORY

ORAL HEALTH: EXCELLENT GOOD FAIR POOR

Date of Last Dental Visit: ______________________ Treatment Type: ______________________

Would you like to have an oral cancer screening performed? Y N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

Y N Are you currently having dental discomfort? If yes, explain:

Y N Any unhappy/unpleasant dental experiences? If yes, explain:

Y N Any injuries to mouth/teeth/head? If yes, explain:

Y N Any missing teeth other than wisdom teeth or orthodontic extractions?
Y N Have missing teeth been replaced?
Y N Orthodontic appliances now or in the past?
Y N Gums bleed when brushing or flossing?
Y N Concerned about gum disease? History of gum disease? 0Y0N
Y N Any concerns about the appearance of your teeth?
Y N Does it hurt to bite or chew?
Y N Do you clench or grind your teeth? If so, do you wear a night guard or splint? 0Y0N
Y N Do you want to become a regular continuing care patient in our practice?
Y N Do you want your mouth properly restored and pain free?
Y N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Have you ever had Onabotulinumtoxina (Botox) or Facial Fillers before? It yes, please explain below: Y N

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

Y N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
Y N Any unusual speech habits? If yes, explain: ______________________
Y N Any lost teeth? If yes, list: ______________________
Y N Does the patient receive assistance with brushing and flossing? If yes, how often?

PRIMARY PHYSICIAN INFORMATION

Physician: ______________________________ Telephone: ______________________

MEDICAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

Y N Under a physician's care now?
Y N Any hospitalization in the past 5 years?
Y N Any serious illnesses/surgeries?
Y N Use tobacco in any form? If Yes, Type:
Y N Is pre-medication required before dental visits due to heart condition or artificial joint?
Y N Taking any prescription or daily OTC medications/drugs? If yes, list details in the Medication Section.

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Due Date: ______________________

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? Y N
If yes, please describe:

Is there anything important about your medical condition we have not asked? Y N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

ACID REFLUX
ADHD
AIDS/HIV
ANEMIA
ANOREXIA
ANXIETY
ARTIFICIAL HEART VALVE
ARTIFICIAL JOINTS
ARTHRITIS
ASTHMA
AUTISM/ASPBERGER'S
BLEEDING DISORDER
BULIMIA
CANCER/MALIGNANCY
CEREBRAL PALSY
CHEMICAL DEPENDENCY
CHICKEN POX
CONVULSIONS
DEPRESSION
DIABETES
DIZZINESS/FAINTING
EPILEPSY/SEIZURES
FREQUENT EAR INFECTIONS
FREQUENT HEADACHES
HEARING PROBLEMS
HEART ATTACK
HEART DISEASE
HEART MURMUR
HEPATITIS
HIGH BLOOD PRESSURE
KIDNEY DISEASE
LIVER PROBLEMS
MITRAL VALVE PROLAPSE
MONONUCLEOSIS
PACEMAKER
OTHER — PLEASE LIST:
PSYCHIATRIC TREATMENT
RADIATION/CHEMO
RESPIRATORY DISEASE
RHEUMATIC FEVER
SINUS PROBLEMS
STROKE
THYROID CONDITION
TUBERCULOSIS
ULCERS
VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

ASPIRIN
ANESTHETIC — LOCAL
BARBITURATES
OTHER— PLEASE LIST: ______________________
CODEINE
DAIRY
LATEX
LACTOSE INTOLERANCE
METAL SENSITIVITY
NITROUS OXIDE SEDATION
SLEEPING PILLS
SULFA DRUGS
PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

ANTIBIOTICS/SULFA DRUGS
BLOOD THINNERS
INSULIN
OTHER DIABETIC MEDICATIONS
OTHER (PLEASE LIST BELOW)
ANTIHISTAMINES/ALLERGY
CANCER/CHEMO MEDICATIONS
NITROGLYCERIN
RECREATIONAL DRUGS
DAILY ASPIRIN
CORTISONE/STEROIDS
ORAL CONTRACEPTIVES
THYROID MEDICATIONS
BLOOD PRESSURE MEDICATIONS
HEART MEDICATION/DIGITALIS
OSTEOPOROSIS MEDICATIONS
TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

FINANCIAL GUIDELINES

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in-network provider for your plan. If we are not an in-network provider, review your plan details, as in many cases insurance reimbursement is very similar.

No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference. Contract write offs will apply only to plans our office is in network for and for procedures the insurance carrier lists as being a covered procedure for any claim submitted.

Payments

Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced, the person accompanying the minor will be responsible for payment at the time of service.

Patient portion or patient co-pays are due at the time services are rendered - unless prior financial arrangements have been made and approved by our office.

Payment Information:

- All major credit cards are accepted (Visa, MasterCard, Discover, AMEX)
- 10% Discount for our uninsured cash/check paying patients
- Financing options with CareCredit®
- In-House Insurance purchased in office providing disounts and preventative care coverage (see office manager for details, purchase options, and application information)

Balances left over 90 days will be turned over to our collection department. Any balances due, including all collection fees, interest, and other charges will be the sole responsibility of the patient/responsible party.

NSF Checks

If any check is returned NSF, the patient and/or responsible party will be responsible for any bank fees incurred by Mekari Laser Dentistry in addition to a $25 dollar inconvenience fee.

Copies of Records

There is a $35 dollar charge for the release of x-rays, clinical notes, and progress notes

Short Cancelled/ Missed Appointments

Please give 48 hours notice if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

Short canceled or missed appointments will be a $75.00 charge per hour scheduled.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: ____

Date: ____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2020

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____ ________________________

Signature Date

RELATIONSHIP TO PATIENT: ADULT PATIENT PARENT GUARDIAN OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

____

____

I give permission for the following communications to be used by Mekari Laser Dentistry (please check all that apply) :

Cell phone: Text Message reminders permitted

Home phone Work E-Mail

I am granting permission for Mekari Laser Dentistry to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for Mekari Laser Dentistry to leave a message with any person who may answer my phone or on my voicemail of the following numbers (please check all that apply):

Home Phone Cell Phone Work Phone None- please just ask for a call back

Other (Please explain) ______________________

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

NAME: ____________________________ RELATIONSHIP TO PATIENT: ______________________

NAME: ____________________________ RELATIONSHIP TO PATIENT: ______________________

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

The patient refused to sign
Communication barriers
Emergency situation
Other – please list: ____

PATIENT CONSENT – PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Mekari Laser Dentistry of the dental benefits otherwise payable to me.

I hereby authorize Mekari Laser Dentistry to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

I understand and agree that by signing this form I am giving Mekari Laser Dentistry full consent to provide treatment for all procedures which are performed and services which are provided.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature of Patient/Responsible Party: ____

Patient Name (Printed): ____

Date: ____