Storyville
FAMILY DENTISTRY

815 N Causeway Blvd., Metairie, LA 70001
504-831-4009
storyvilledentistry@gmail.com

Who may we thank for referring you?

_____

Name(Last, First): _____
Nickname:_____
☐ Male ☐ Female

Mailing Address:_____
City, State, Zip Code:_____
Date of Birth:_____
Social Security Number:_____
☐ Single ☐ Married ☐ Other

Employer:_____
Occupation:_____

Cell Phone:_____
Home/Work Phone:_____
Email:_____

Opt In: ☐ Email ☐ Text
Spouse:_____
Spouse Contact #:_____
Emergency Contact Name/Number:
☐ Spouse (see above)
_____
Name Phone #:

Are you happy with your teeth/smile? ☐ Yes ☐ No
If no, explain why you're unhappy:_____

How often do you floss?_____
Date of last dental visit:_____

How often do you brush?_____
Date of last dental x-rays:_____

Previous Dentist(name and phone #):_____

DENTAL HISTORY

Check if you have or have had:

- ☐ Bad Breath
- ☐ Blisters (Lip or Mouth)
- ☐ Burning sensation on tongue
- ☐ Chew on one side
- ☐ Dry Mouth
- ☐ Food Collection
- ☐ Clench / Grind
- ☐ Growths/Sore Spots
- ☐ Bleeding, Sore Gums
- ☐ Head/Neck/Jaw Pain
- ☐ Lip/Cheek Chewing or Biting
- ☐ Loose Teeth / Broken Fillings
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment (Braces)
- ☐ Periodontal Treatment
- ☐ Hot or Cold Sensitivity
- ☐ Dental Anxiety
- ☐ POWER-BRUSH USER

Check Yes or No:

Smoking/ Vaping	☐ Yes	☐ No
Chewing Tobacco	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No

Allergies:

Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
General Anesthesia	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No

Other: _____

☐ No Known Drug Allergies

Patient Name (Last, First):_____ Date:_____

Medical Physician Name:_____Phone Number:_____

Date of Last Checkup:_____

MEDICAL HISTORY

Check if you have or have had:

- ☐ Allergies, hay fever, sinusitis
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding abnormally with surgery
- ☐ Blood Disease/Clotting Disorders
- ☐ Blood Transfusion
- ☐ Cancer/ Radiation/Chemotherapy
- ☐ Chemical Dependency
- ☐ Coronary Artery Disease
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis, Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/Aids
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pre-Medication Needed (antibiotics)
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sickle Cell Anemia
- ☐ Skin Rash
- ☐ Stroke Stroke
- ☐ Swelling of Feet and Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth (Head or Neck)
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained
- ☐ Other:_____

Are you nursing ☐ or pregnant ☐ ?

List any Medications you take:

_____

_____

_____

DENTAL INSURANCE

Storyville Dentistry provides insurance company billing as a courtesy. The patient portion of particular dental services are estimated and due at the time of service. This amount may be subject to adjustment when the dental service claim is processed by the insurance company. In addition certain insurance companies have annual deductibles and maximums for dental policies that may cause the estimates to be different than the final payment amount by the insurance company. The patient is fully responsible for all charges not paid by the insurance company.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I also understand that my dental care insurance carrier or payer of my dental benefits may pay LESS than the actual bill for services.
I am financially responsible for payments in full of all accounts. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

Signature :_____ Date:_____

Insurance Company:_____
Insurance Company Phone #:_____
Group Number:_____
Group Name/ Employer:_____
Subscriber ID #:_____
Subscriber: ☐ Myself or ☐ _____
Subscriber Date of Birth:_____

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment for the purpose of evaluating and administering **claims for dental insurance benefits**.

_____
Signature Date