

*Dr. Lawrence N. Frost, III*  
**D.D.S.**  
*General & Family Dentistry*

525 Metairie Road • Metairie, LA 70005  
 (504) 833-2500 • Fax (504) 833-7080

**PATIENT INFORMATION**

NAME \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
LAST FIRST M.I.

NICKNAME \_\_\_\_\_ S.S. # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

TELEPHONE \_\_\_\_\_ EXT. # \_\_\_\_\_  
HOME WORK BEEPER OR CELL PHONE

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE?  YES  NO IF YES, PLEASE GIVE NAME \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME \_\_\_\_\_  
LAST FIRST M.I.

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

TELEPHONE \_\_\_\_\_ EXT. # \_\_\_\_\_  
HOME WORK BEEPER OR CELL PHONE

S.S. # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**FAMILY INFORMATION**

SPOUSE / PARENT'S NAME \_\_\_\_\_  
LAST FIRST M.I.

EMPLOYER \_\_\_\_\_ WORK # \_\_\_\_\_

S.S. # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ HOME # \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

INSURED'S NAME \_\_\_\_\_

INSURANCE CO. (PRIMARY) \_\_\_\_\_

INSURANCE CO. (SECONDARY) \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_

INSURED'S ID # OR S.S. # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

GROUP # \_\_\_\_\_ TELEPHONE \_\_\_\_\_

Your dental insurance is your responsibility BUT WE CAN HELP... Regardless of what we might calculate as your benefits in dollars, we must stress the fact that you, the patient, are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefits from most insurance companies. This will reduce your immediate out of pocket expenditures. Any estimate is based on limited information obtained from your insurance company. We do not have a contract with your insurance company only you do. We are not responsible for how your insurance company pays its claims. We allow 45 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

**METHOD OF PAYMENT**

CASH  CHECK  DEBIT CARD  CREDIT CARD

WE DO NO BILLING. All balances must be paid in full at the time of service. By signing as responsible party below, you are stating that you understand that any balance left after insurance payments must be paid within 30 days. Failure to pay the balance in 30 days will result in an \$8.00 monthly billing charge. In the case of default of payment, you promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

**AUTHORIZATION**

I hereby authorize payment directly to DR. LAWRENCE N. FROST, III of insurance benefits otherwise payable to me. I understand that I am personally responsible for all costs of dental treatment. I hereby request and authorize DR. LAWRENCE N. FROST, III to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history (on the next or separate page provided) are true and correct to the best of my knowledge. If I have any changes in my health, I will inform my dentist.

I am in a legal position to agree to the authorization above and claim responsibility for this patient as well as the payment for all treatment.

X  ADULT PATIENT  PARENT  GUARDIAN  OTHER (SPECIFY) \_\_\_\_\_

(OVER) DATE \_\_\_\_\_

## HEALTH HISTORY

(Confidential)

### DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe \_\_\_\_\_ YES NO

When was your last dental visit or X-rays? \_\_\_\_\_

Have you ever had a bad experience in a dental office? Describe \_\_\_\_\_ YES NO

Are you interested in using nitrous oxide or I.V. sedation for your dental appointments? \_\_\_\_\_ YES NO

Do your gums ever bleed? Discuss \_\_\_\_\_ YES NO

Do you want to keep your remaining teeth? ..... YES NO

Are you interested in whitening your teeth? ..... YES NO

Are you happy with your smile? ..... YES NO

Do you have bad breath? ..... YES NO

Name of previous dentist? \_\_\_\_\_

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

### MEDICAL HISTORY

Medical doctor's name \_\_\_\_\_ Phone Number \_\_\_\_\_

Are you under a doctor's care now? Why? \_\_\_\_\_ YES NO

Have you been hospitalized during the past two years? Why? \_\_\_\_\_ YES NO

(Women) Are you pregnant? ..... YES NO

Nursing? ..... YES NO

Taking birth control pills? ..... YES NO

Have you ever been treated or diagnosed with any of the following? CIRCLE yes or no next to EACH one.

AIDS / HIV	YES	NO	Glaucoma	YES	NO	Liver Disease	YES	NO	Stomach Problems	YES	NO
Anemia	YES	NO	Hay Fever	YES	NO	Mitral Valve Prolapse	YES	NO	Stroke	YES	NO
Arthritis	YES	NO	Head Injuries	YES	NO	Mental Disorders	YES	NO	Thyroid Disorders	YES	NO
Artificial Joints / Valves	YES	NO	Heart Disease	YES	NO	Nervous Disorders	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Heart Murmur	YES	NO	Pacemaker	YES	NO	Tumors	YES	NO
Blood Disease	YES	NO	Hemophilia	YES	NO	Psychiatric Problems	YES	NO	Ulcers / Colitis	YES	NO
Cancer	YES	NO	Hepatitis A B or C	YES	NO	Radiation Treatment	YES	NO	Venereal Disease	YES	NO
Diabetes	YES	NO	Herpes	YES	NO	Respiratory Problems	YES	NO			
Dizziness	YES	NO	High Blood Pressure	YES	NO	Rheumatic Fever	YES	NO	Do you have a tobacco habit?		
Epilepsy	YES	NO	Jaundice	YES	NO	Rheumatism	YES	NO		YES	NO
Fainting	YES	NO	Jaw Problems	YES	NO	Scarlet Fever	YES	NO			
Fever Blisters	YES	NO	Kidney Disease	YES	NO	Sinus Problems	YES	NO	Are you pregnant?	YES	NO

### MEDICATIONS

List medications you are currently taking.

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone Number \_\_\_\_\_

### ALLERGIES

Are you allergic to:

Aspirin	YES	NO	Penicillin	YES	NO
Codaine	YES	NO	Sulfa	YES	NO
Latex	YES	NO	Other	_____	
Local Anesthetic	YES	NO		_____	

### SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form. (Strictly Confidential)

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

Dr. Lawrence N. Frost, III, D.D.S.

---

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

---

**\*You May Refuse to Sign This Acknowledgment\***

I, the undersigned \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

PLEASE PRINT NAME

---

SIGNATURE

---

DATE

---

FOR OFFICE USE ONLY

---

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgment
  - An emergency situation prevented us from obtaining acknowledgment
  - Other (Please Specify)
- 
- 
-

# *Frost Family Dental Care*

525 Metairie Road  
Metairie, LA 70005  
(504) 833-2500

## **WELCOME TO OUR OFFICE**

**HYGIENE APPOINTMENTS:** We at Frost Family Dental Care consider your time as valuable as our professionals. For this reason, we do not overlap patient appointments with our Hygienists. The required time for each hygiene procedure is actually reserved **JUST FOR YOU**.

Please take all the time you need in selecting a date and time that you are sure you can make. If for any reason you doubt that you will be able to keep an appointment, please let us know at least one (1) working day in advance so the reserved time can be released to another patient.

**DOCTOR'S APPOINTMENTS:** We try our very best to see our scheduled patients at the appointed time. We understand that unexpected things happen that may prevent you from arriving on time. There may also be emergencies or unexpected patient conditions that cause us to run slightly behind schedule. As a courtesy to you, if this occurs, you will be informed so you can decide whether you want to wait or reschedule. If you are running late, we will have to decide at the time you arrive if there is enough time to complete your treatment. We do this to help keep our schedule flowing smoothly.

**EMERGENCY PATIENTS:** It is our goal to see emergency patients on the same day. Calling us early in the day will allow us to give you the best time to arrive, as we will be working you in, around our previously scheduled patients. Emergencies should be a chipped or broken tooth, or a sudden onset of pain in a particular area of the mouth. We ask that all other patients call us at the **FIRST** sign of minor discomfort. This will allow us time to give you an actual appointment and treat the symptoms before they become severe.

### **PAYMENT OPTIONS:**

1. Pay as you go with cash, check or credit card. If treatment rendered exceeds \$200, a 5% Courtesy Adjustment will be given to those paying with cash.
2. We accept all major credit cards and debit cards.
3. 12 months interest free financing through a local finance company for treatment plans \$400 up to \$7,500 with an approved credit application.

**CANCELLATION POLICY:** We do charge \$45 for appointments missed without notice of at least one working day. Any patient missing two appointments without notice will be required to make a non-refundable deposit for all future appointments. Missed appointments are very costly and this policy is necessary if we are to keep our schedule, pricing, and staff available and affordable for our patients.

Thank you for choosing our office, we look forward to a long, mutually rewarding relationship!

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**Frost Family Dental Care  
525 Metairie Road  
Metairie, LA 70005  
( 504 ) 833-2500**

## **Insurance and Payment Policy**

All insurance claims will be filed for you, most times electronically, on the date of service. In an effort to keep our costs affordable for you, the patient, we ask that you pay your portion in full at the time of service. Unless other arrangements have been made with the financial coordinator. Your insurance company will release benefits to the office, usually within 2–3 weeks after receiving the claim. Our office will follow up with your insurance company to ensure that the claim is being paid properly.

If for any reason your insurance company does not pay the claim, the patient or responsible party will be billed. If an account becomes 90 days past due, it is then turned over to collections and a \$25.00 billing fee plus all attorney costs are added to the account, becoming your responsibility.

*I have read and understand the above. By signing, I understand I am also responsible for any and all collection and/or attorney costs that Frost Family Dental Care incurs in settling my account.*

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date