PATIENT INFORMATION

Name: Mr Mrs Ms Miss_____Preferred Name_____

Address_____City _____State_____Zip_____

Home Phone_____Work Phone_____Other Phone_____

DOB_____Sex_____SSN_____Age_____Marital Status: S M D W

Employer_____Occupation_____

Driver's License #_____ State_____Exp Date_____E-Mail_____

Patient Lives with (Please Circle): Self Parent Guardian

If patient is a minor, name of the person the minor lives with_____

Is an immediate family member a patient here?_____Name_____

Daytime call(Please Circle): Home Work Other

Person to contact in case of emergency_____Phone_____

Whom can we thank for referring you?_____

RESPONSIBLE PARTY INFORMATION

Self (Yes/No)_____Other_____Relationship_____

If other please complete:

Social Sec. #_____DOB_____Home Phone_____Work Phone_____

Address_____City_____State_____Zip_____

INSURANCE INFORMATION

Insured's Name_____Birth Date_____

Insured's Social Sec.#_____Insured's Employer_____

Insurance Co._____Group#_____Local#_____

Insurance Co. Address_____Phone_____

Do you have dual coverage? Yes___ No___ List secondary information below:

Insurance Co._____Group#_____Local#_____

Insurance Co. Address_____Phone_____

I hereby authorize payment directly to Thomas A. Bailey, DDS, Family Dentistry LLC, of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment at the time of service unless this cost is covered by insurance. I hereby authorize this Dental Office to administer such medications and perform such diagnostics, photographic, therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge.

Signature_____ Date_____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	___	___
If yes, a brief description of the treatment. _____		
2. Have you ever been hospitalized for any surgical operation or serious illness?	___	___
If yes, a brief description _____		
3. Are you taking any medication(s) including non-prescription medicine?	___	___
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen Phen or Redux?	___	___
5. Do you use tobacco or alcohol? Please specify_____	___	___
6. Do you use cocaine or other drugs? Please specify_____	___	___
7. Do you have any other physical conditions?	___	___
If yes, please describe _____		
8. Are you allergic to or have you had any reactions to the following:		
Local anesthetics (eg. Novacaine), codeine, aspirin, penicillin or other antibiotics,		
Sedatives, sulfa drugs, latex or iodine?	___	___
If yes, list medications. _____		
9. Other allergies not listed above. _____		
10. For women only:		
a) Are you pregnant or think you may be pregnant?	___	___
b) Are you nursing?	___	___
c) Are you taking birth control pills?	___	___
11. Do you have or have you had any of the following?	___	___

Yes	No	Yes	No	Yes	No
___	___High Blood Pressure	___	___ Heart Disease	___	___ Chest Pains
___	___Heart Attack	___	___Cardiac Pacemaker	___	___ Easily Winded
___	___Rheumatic Fever	___	___Heart Murmur	___	___ Stroke
___	___Swollen Ankles	___	___Angina	___	___ Hay Fever/Allergies
___	___Fainting/Seizures	___	___Frequently Tired	___	___ Tuberculosis
___	___Asthma	___	___Anemia	___	___ Radiation Therapy
___	___Low Blood Pressure	___	___Emphysema	___	___ Glaucoma
___	___Epilepsy/Convulsions	___	___Cancer	___	___ Recent Weight Loss
___	___Leukemia	___	___Arthritis	___	___ Liver Disease
___	___Diabetes	___	___Joint Replacement or Implant	___	___ Mitral Valve Problem
___	___Kidney Disease	___	___Hepatitis/Jaundice	___	___ Respiratory Problems
___	___AIDS or HIV Infection	___	___Sexually Transmitted Disease	___	___ Chemical Dependency
___	___Thyroid Problem	___	___Stomach Troubles/Ulcers	___	___ Other _____
___	___Abnormal Bleeding	___	___Blood Transfusion	___	___ _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature _____ Date _____

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	___	___
2. Are your teeth sensitive to hot or cold liquids/foods?	___	___
3. Are your teeth sensitive to sweet or sour liquids/foods?	___	___
4. Do you feel pain to any or you teeth?	___	___
5. Do you have any sores or lumps in or near your mouth?	___	___
6. Have you had any head, neck or jaw injuries?	___	___
7. Have you ever experienced any of the following problems		
in your jaw?	___	___
a) Clicking?	___	___
b) Pain (joint, ear, side of face)?	___	___
c) Difficulty in opening or closing?	___	___
d) Difficulty in chewing?	___	___
8. Do you have frequent headaches?	___	___
9. Do you clench or grind your teeth?	___	___
10. Do you bite your lips and cheeks frequently?	___	___
11. Have you ever had any difficult extractions in the past?	___	___
12. Have you had any orthodontic treatment?	___	___
13. Have you ever had prolonged bleeding following extractions?	___	___
14. Have you ever had instruction on the correct method of brushing your teeth?	___	___
15. Have you ever had instructions on the care of your gums?	___	___
16. Have you ever had radiation therapy to the head and/or neck?	___	___

Date of last dental visit/exam _____

Have you ever had any complications before, during or after dental treatments? _____

If so, what? _____

What is your present dental problem or concern? _____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature _____ Date _____

Please read before consenting to treatment

Thomas A. Bailey, D.D.S.
Family Dentistry
2301 N. Hwy 190 Ste. 4
Covington, LA 70433

OUR FINANCIAL POLICY

Welcome to our practice! We truly hope that you have come to our office confident that you will receive the best dental care we can provide. That is our number one priority. We invite you to discuss your treatment and fees at any time. We will make our staff available to explain the details of your treatment as well as the costs involved and make every effort to be accurate and clear in our explanations.

If you have dental insurance, we ask that you become familiar with your premium and benefits and financial obligations. Our staff is here to help process your claims and only **estimate your benefits.** Please remember:

As a ***courtesy*** to our patients who have dental insurance, we will file your claim, **but payment of your portion is expected at the time services are rendered.**

It is important to remember that the insurance contract is between you and your insurance company.

Concerns or issues regarding insurance company payments on your account should be addressed first to your insurance company, then to our office.

Insurance companies do not guarantee that your services will be paid, therefore procedures not paid or covered by your insurance company are to be paid in full by the patient.

We do accept the following payment options for your convenience. CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS and CARE CREDIT.

There will be a cancellation/failure fee of $35.00 per hour scheduled for each appointment cancelled/failed within 24 hours.

Quality dental care is important to your overall all health. We appreciate your confidence in us and our staff and look forward to serving you.

I understand the financial policy of this office and agree to its terms.

_____

Patient or Guardian Signature

Thomas A Bailey D.D.S. Family Dentistry L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this offices Notice of Privacy Practices.

_____

(Please Print Name)

_____ _____

(Signature) **(Date)**

For Office Use Only

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

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

_____

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