Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (___) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Cell Phone #1 (___) _____ Cell Phone #2 (___) _____

Employer/School _____ Employer/School Phone (___) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (___) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (___) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (___) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (___) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (___) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (___) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (___) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

– OVER –

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DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

TERRY J. BILLINGS, DDS, APDC

3101 7TH STREET
METAIRIE, LOUISIANA 70002
504-832-2222 FAX 504-832-2111

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I, _____, hereby authorize Terry J. Billings, DDS, APDC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the physician can refuse to treat me.

I have been informed that Terry J. Billings, DDS, APDC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Terry J. Billings, DDS, APDC in writing, but if I revoke my consent, such revocation will not affect any actions that Terry J. Billings, DDS, APDC took before receiving my revocation.

I understand that Terry J. Billings, DDS, APDC has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Terry J. Billings, DDS, APDC restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Terry J. Billings, DDS, APDC does not have to agree to such restrictions, but that once such restrictions are agreed to, it must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____ Please initial here if you would like to give us permission to speak with someone in your household regarding your care or account status. List person(s): _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Please understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance or any other balance not paid by your health plan. For Medicare patients, this represents any unmet deductible and 20% of the allowed amount.

All payments are due at the time of service. All patient-due amounts must be paid within 30 days. If this creates a financial hardship for you, please contact our business office. In no case can we extend payment past four (4) months. All past-due accounts are placed with an outside agency for collection.

Checks returned for non-sufficient funds must be paid within five (5) business days from the time we notify you. Uncollected NSF checks are placed with the District Attorney's office for collection.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

To Be Completed If Patient Is Unable To Sign:

_____ _____

Printed name of patient or patient's representative **Relationship to the patient**

Name_____ Date_____

Height_____ Weight_____

Do you experience any of these symptoms?

- ___ **Difficulty Concentrating**
- ___ **Excessive Daytime Sleepiness**
- ___ **Fatigue**
- ___ **Wake up not feeling refreshed**
- ___ **Morning Headaches**
- ___ **Dry Mouth or throat after waking up**
- ___ **Difficulty Losing Weight**
- ___ **Sleepiness While Driving**
- ___ **Frequent Naps**
- ___ **Snoring**
- ___ **Gasping or choking While Sleeping**
- ___ **Excessive Movement at Night**
- ___ **Waking up to Urinate**
- ___ **Grinding Teeth While Sleeping**
- ___ **Use of a sleep aid**
- ___ **CPAP intolerant**
- ___ **Use Nasal Spray daily or often**

- ___ **Insomnia**
- ___ **Hypertension**
- ___ **Diabetes**
- ___ **Acid Reflux/GERD**

Use the following scale to choose the most appropriate number for each situation:

- 0 = would never dose or sleep.
- 1 = slight chance of dozing or sleeping
- 2 = moderate chance of dozing or sleeping
- 3 = high chance of dozing or sleeping

Situation	**Chance of dozing or sleeping**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score (add the scores up) (This is your Epworth score)	_____