Welcome

TO OUR PRACTICE

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 _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ ☐ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

E-mail _____ Alt. Phone #1 (____) _____ Alt. 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 –

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 used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Congenital Heart Lesions	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc.	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding Abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic Fever			

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**

TERRY J. BILLINGS, D.D.S.

A PROFESSIONAL DENTAL CORPORATION
FAMILY DENTISTRY

Patient Responsibility

According to industry standards, our billing department will file your claims for all applicable dental and medical services and appliances rendered to you by our physicians. As a courtesy to our patients, this office will also send claims, letters, x-rays, and any other necessary information to your insurance carrier for the reimbursement of those charges.

As your insurance policy is a contract made between you and your insurance carrier, you, the patient, are responsible for monitoring the use of your policy's benefits and for remaining within your yearly maximum covered benefit allowances. If you require dental treatment, we will compose a treatment plan for you. Any and all pricing and figures are derived from percentages that have been provided to our staff by your insurance carrier and is only an estimate of your out of pocket cost.

A member of our staff will call your insurance carrier to obtain your benefit's information, however, that information is not always accurate If your insurance carrier places any financial responsibility to you, you will be responsible for your bill. We make every effort to know how your insurance carrier will cover your care during your visit with our office, however, often the benefits information we receive from insurance carriers is not accurate. It is your responsibility to call your insurance carrier before receiving treatment with this office to insure we are a provider for your insurance plan, and to learn for yourself how you will be covered for your visit.

In all cases, if your insurance carrier fails to reimburse our physician's for their services, then you, the patient, are responsible for those charges.

Estimated percentages and patient portions your insurance company does not cover for your treatment are to be collected by our staff on the day of service. If your insurance company does not pay the entire estimated insurance portion, you will be responsible for the difference. Once you have reached your maximum insurance benefit amount allowed and there are still other procedures or treatment to be complete, then any cost accumulated will be your responsibility.

By signing this document, I understand that insurance estimates are **not** a guarantee of payment. Nor is it a guarantee that services rendered are to be covered by my dental/medical insurance provider. Any balance left unpaid by my insurance carrier becomes my responsibility.

Signature: _____ **Date:** _____

3101 7th St. Metairie, LA 70002 Phone: 504.832.2222 Fax: 504.832.2111 www.tjbillingsdds.com

Patient Name: _____

Date: _____

Do you currently experience any of the following symptoms?

Please read through the list on both sides, **and then** pick your top chief complaints. Number them in order with the most severe being number 1.

		Recent	Chronic
__	Headache (inside your head)	☐	☐
__	Headache (outside your head)	☐	☐
__	Jaw Pain	☐	☐
__	Chewing Pain	☐	☐
__	Face Pain	☐	☐
__	Eye Pain	☐	☐
__	Throat Pain	☐	☐
__	Neck Pain	☐	☐
__	Shoulder Pain	☐	☐
__	Back Pain	☐	☐
__	Dyskinesia	☐	☐
__	Difficulty Opening Mouth	☐	☐
__	Difficulty Closing Mouth	☐	☐
__	Noises in Jaw Joint	☐	☐
__	Ear Stuffiness	☐	☐
__	Dizziness	☐	☐
__	Ringing in Ears (Tinnitus)	☐	☐
__	Vision Problems	☐	☐
__	Muscle Spasms	☐	☐
__	Sinus Congestion	☐	☐
__	Kicking or Jerking Leg Repeatedly	☐	☐
__	Swelling in Ankles or Feet	☐	☐
__	Numbness (Localized)	☐	☐
__	Nerve Pain	☐	☐
__	Dental Changes	☐	☐
__	Teeth Spacing	☐	☐
__	Teeth Sensitivity	☐	☐
__	Changes with your Bite	☐	☐
__	Any other symptoms not listed above:_____		

		Recent	Chronic
__	Morning Hoarseness	☐	☐
__	Dry Mouth Upon Wakening	☐	☐
__	Fatigue	☐	☐
__	Difficulty Falling Asleep	☐	☐
__	Tossing and Turning Frequently	☐	☐
__	Repeated Awakening	☐	☐
__	Feeling Un-refreshed in the Morning	☐	☐
__	Morning Headaches	☐	☐
__	Nighttime Urination	☐	☐
__	Night Sweats	☐	☐
__	Vivid Dreams	☐	☐
__	Sore Jaw Upon Waking	☐	☐
__	Significant Daytime Drowsiness	☐	☐
__	Affect Sleep of Others	☐	☐
__	Short of Breath When Waking	☐	☐
__	Told "I Stopped Breathing During the Night"	☐	☐
__	Night Time Choking Spells	☐	☐
__	Unable to tolerate the CPAP	☐	☐
__	Tooth Grinding	☐	☐
__	Tooth Crowding	☐	☐
__	Frequent Heavy Snoring	☐	☐
__	Acid Indigestion	☐	☐

Below for office use only

Commments_____

_____

Doctors Initials_____

BILLINGS FAMILY DENTISTRY

PATIENT QUESTIONNAIRE FOR SLEEP APNEA AND SNORING

Name: _____ Birthdate ___/___/___ Age: _____ Date: _____

Present Weight: _____ Height: _____ Weight gained in last 12 months: _____ Sex: M ☐ F ☐

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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

0 = would **never** dose
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

Situation	Chance of dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in public place (e.g. theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In car, while stopped for a few minutes in the traffic	_____
TOTAL SCORE	_____

1. How long have you been aware of your snoring? _____
2. Have you been told your breathing stops while asleep? Y ☐ N ☐
3. About how many times per night do you wake up? _____
4. Do you have any difficulty falling asleep at night? Y ☐ N ☐
5. How many hours of sleep per night do you get? _____
6. Do you most often wake up feeling refreshed? Y ☐ N ☐
7. Does a small amount of alcohol give you a headache? Y ☐ N ☐
8. Have you seen other doctors about snoring or apnea? Y ☐ N ☐ Who and When? _____
9. Have you had a sleep lab study? Y ☐ N ☐
10. Do you have difficulty breathing through your nose? Y ☐ N ☐
11. Do you know if you have any heart irregularities? Y ☐ N ☐
12. Do you have high blood pressure? Y ☐ N ☐ What is yours? _____/_____
13. Do you have any loss of memory? Y ☐ N ☐ Depression? Y ☐ N ☐
14. What is your normal bedtime? _____ Wake up time? _____
15. Does your work/sleep schedule change? Y ☐ N ☐

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Please answer the following questions by indicating frequency according to these guidelines:

Daily - Every or almost every night or day
Often - At least once or twice per week
Infrequently - Less than once a week
Never

During your usual sleep, have you noticed or have you been told that you do the following: (check one answer in each category)

		Daily	Often	Infreq	Never
A.	Snore loudly	☐	☐	☐	☐
B.	Choke, struggle for breath or stop breathing	☐	☐	☐	☐
C.	Awaken repeatedly because of a breathing problem	☐	☐	☐	☐
D.	Toss and turn frequently	☐	☐	☐	☐
E.	Kick or jerk legs repeatedly	☐	☐	☐	☐

When you wake up after your usual sleep, how often do you experience the following:

		Daily	Often	Infreq	Never
A.	Headache	☐	☐	☐	☐
B.	Dry mouth	☐	☐	☐	☐
C.	Feel tired or unrested	☐	☐	☐	☐

During the time when you are usually awake (daytime and evening), how often do you become irresistibly sleepy or do you fall asleep in the following situations:

		Daily	Often	Infreq	Never
A.	After a meal	☐	☐	☐	☐
B.	Reading or watching TV	☐	☐	☐	☐
C.	At church or school	☐	☐	☐	☐
D.	At work	☐	☐	☐	☐
E.	While a passenger in a vehicle	☐	☐	☐	☐
F.	While driving a vehicle	☐	☐	☐	☐

Do you have trouble breathing through your nose:

		Daily	Often	Infreq	Never
A.	Daytime	☐	☐	☐	☐
B.	Nighttime, in bed	☐	☐	☐	☐

Do you consume any alcoholic beverages or take sedatives:

		Daily	Often	Infreq	Never
A.	Daytime	☐	☐	☐	☐
B.	Nighttime, in bed	☐	☐	☐	☐

Have you had or used any of the following:

Nose broken	Y ☐	N ☐	Nose surgery	Y ☐	N ☐	Tonsillectomy	Y ☐	N ☐
Hay fever	Y ☐	N ☐	Sinus problems	Y ☐	N ☐	Antihistamines	Y ☐	N ☐
Cigarettes	Y ☐	N ☐	Nasal sprays	Y ☐	N ☐	Prev. treatment	Y ☐	N ☐

Do you take medications for:

Heart condition	Y ☐	N ☐	Respiratory condition	Y ☐	N ☐
Thyroid condition	Y ☐	N ☐	Metabolism (weight)	Y ☐	N ☐

What medications do you take? _____

_____

Signature _____ Date _____