PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Employer`s name

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Dr. Curtis J. Zeringue

Eaglesoft Medical History

Date 9/20/2016

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ **Date:**_____

Patient Questionnaire

Are your teeth sensitive to: (circle all that apply?)

Hot or cold: YES NO
Biting/chewing: YES NO
Sweets: YES NO

Have you ever had?
Orthodontic treatment: YES NO
A bite plate or guard: YES NO
Gum treatment: YES NO
Oral surgery: YES NO

Serious injury to mouth or head: YES NO
Comments:

How often do you brush? _____
What type of bristles? SOFT MEDIUM HARD
How often do you replace your toothbrush? _____
Do your gums bleed? _____
Do you like your smile? _____
Your current dental health? GOOD FAIR POOR

ACKNOWLEDGEMENT

1. **Parents/Legal Guardians**: I hereby certify that I am the legal guardian for the child whose information is entered in this form. I hereby authorize Bayou Dental Care, with my consent, to perform any and all necessary treatment in connection with the dental care of the patient above. Initial: _____

2. **Insurance Claims**: You don't have to sign an insurance form at each dental visit. Bayou Dental Care will maintain your "Signature on File". AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to Bayou Dental Care for services rendered. Initial: _____ AUTHORIZATION TO RELEASE INFORMATION: I further authorize any provider, insurer or organization to release any information regarding the dental history, treatment or benefits payable to the plan administrator or its authorized agent for the purpose of determining benefits payable. Initial: _____

3. **Insurance Bearers**: I understand that as a courtesy to me Bayou Dental Care will assist me in filing my insurance claims. However, I am completely responsible for all fees in their entirety. I am fully aware that my insurer may not pay in full (or at all) for all services provided by Bayou Dental Care. An estimate of expenses not covered by my insurance is due at the time of service. Initial: _____

4. **Acknowledgement**: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect, inaccurate or insufficient information can jeopardize my (patient's) health and ability to receive care at Bayou Dental Care. It is solely my responsibility to inform Bayou Dental Care of any changes in my medical status or dental insurance coverage at every visit. Initial: _____

5. **Privacy & Financial Policy**: I have received Bayou Dental Care's Notice of Privacy Practices. Initial: _____
I have received Bayou Dental Care's Notice of Financial Responsibility.

Bayou Dental Care
Financial Policy

This notice describes your financial obligation and payment options:

Payment* in full is due at the time services are rendered. For your convenience we accept Cash, Certified Checks, Care Credit, Discover Card, Visa and MasterCard.

Dental Insurance: Insurance benefits are determined by your employer and your insurance carrier, not your dentist. You are responsible to know the scope of your insurance policy and its limitations. Dental insurance is not a guarantee of payment and insurance companies typically will not pay for all of your treatments. If you receive a statement from our office and disagree with how your insurance carrier processed the claim, please call your carrier. You are responsible for payment of any deductible and co-payment amounts at the time of service according to the terms of your insurance policy. Your insurance coverage is a contract between you and your insurer. Your account with us and payment of our fees are your responsibility, not your insurance company's. You will be expected to pay for services rendered, in full, if our office is unable to verify your insurance information prior to treatment. Unless a written Pre-determination of benefits is requested from your insurance carrier ahead of time, we can only estimate the amount your deductible and are unable to calculate an exact amount due to limitations on release of information imposed by dental insurance companies.

Delinquency: We reserve the right to charge and collect a fee for broken appointments. (Appointments that are cancelled or broken without 48-hours advance notice) Exceptions will be made on a case by case basis. Appointment times are reserved exclusively for you. If three appointments are missed by you that we were not properly notified, you may be dismissed from our practice. Returned check fee of $15.00 will be added to your account balance and is collectible. Any account balance overdue longer than 90 days is considered delinquent, immediately collectible, sent to small claims court or collection agencies with notice given to you in advance. You are responsible for any interest, legal or collections related fees. Payment in full of any past due balance and related fees are expected before any further treatment is rendered.

*Complete Payment, Discounts & Down Payment: Complete payment (taking into account down payment and estimated insurance portion) is due at the time of service. A 3% courtesy discount will be applied to the client's treatment if the entire payment is made in full by cash, credit card or certified check prior to the treatment. A down payment equal to full amount of your portion for the service is appreciated to reserve your next appointment time. Exceptions are 6 month checkups and payment plans already in effect.

Payment Plans: We offer extended payment options through Care Credit, which allows for up to 6 or 12 months at no interest and no finance charges, if paid within the promotional period. These payment plans also have extended payment options that allow payments of up to 36 months through a low interest plan. Care Credit is offered through an independent financial institution and are subject to credit review.

As guarantor of my account, I understand that I am solely responsible for all of the fees for the dental treatment. I further agree that I have received a copy of this office financial policy and agree to it's contents.

Print your name:_____ Patient's name if not self:_____

Signature:_____

Bayou Dental Care
Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your health information is important to us here at Bayou Dental Care.

Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on 06/01/2008, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Practice Administrator of this office.

Uses and Disclosures of health information: We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. However nothing in this section requires Crescent Dental to oversee, supervise or dictate the professional activities of duly licensed dental professionals.

Telephone conversations: may be monitored for quality assurance and employee training.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described
in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional

judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. **Required by Law:** We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence. counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, e-mail, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your healthcare information. We may charge you a reasonable cost-based fee for expenses such as copies, postage and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explaining why the information should be amended. We may deny your request under certain circumstances.) **Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.