Barras
FAMILY DENTISTRY

Welcome to our practice!

Please read and fill out all attached forms
so we may serve you better.

PATIENT INFORMATION		
PATIENT Name: First (Middle Initial) Last	Preferred Name	Date of Birth
Address	Gender Select one	Family Status (S. M. W. Other) Single
City State Zip	Home ph #	Work ph #
Employer	Cell ph #	Other ph#
Email address	SS #	Driver's Lic. #

RESPONSIBLE PARTY ☐ SELF (move to spouse/guardian section) ☐ Other(please complete section below)		
Person to be listed as the responsible party of this account (Guarantor):		Who referred you to our office?
Responsible Party's Mailing Address	Date of Birth (Responsible party)	Relationship to Patient Self
City State Zip	Home ph #	Work ph #
Employer	Cell ph #	Other ph#
Email address	SS #	Driver's Lic. #

SPOUSE/GUARDIAN INFORMATION ☐ SINGLE (move to Emergency section) ☐ Married or Patient under 18 (please complete section below)		
Spouse/Guardian Name:	Gender	Spouse/Guardian Date of Birth
Spouse/Guardian Home Address	SS #	Relationship to Patient Single
City State Zip	Home ph #	Work ph #
Employer	Cell ph #	Other ph#

EMERGENCY CONTACTS		
1st Person to contact in case of emergency?	Relationship to pt.	Phone #
2nd Person to contact in case of emergency?	Relationship to pt.	Phone #

PRIMARY DENTAL INSURANCE ☐ None		
Primary Ins	Pri. Ins. Phone	
Group Name	Group #	Relationship to Insured? NO Dental Insurance
Subscriber (Owner of the Ins. Policy)	ID #	Subscriber DOB

SECONDARY DENTAL INSURANCE ☐ None		
Secondary Ins	Sec. Ins. Phone	
Group Name	Group #	Relationship to Insured? NO secondary dental ins.
Subscriber (Owner of the Ins. Policy)	ID #	Subscriber DOB

- I hereby give my permission to release dental treatment and account information to (Please PRINT):

1. _____ _____ _____
Name of person Relationship to pt Initials of pt

2. _____ _____ _____
Name of person Relationship to pt Initials of pt

Barras FAMILY DENTISTRY

Patient's Name (Print) _____ _____

MEDICAL HISTORY

1. Have you been hospitalized or had any surgical procedure? ☐ Yes ☐ No
   If yes, please state reason for hospitalization/surgery: _____
2. Have you ever been under the care of a physician for any major illness or injury? ☐ Yes ☐ No
   If yes, please state major illness or injury: _____
3. Please **LIST** all medications you are currently taking:
   (Include prescribed medications, birth control pills, over-the-counter drugs, vitamins, and supplements)
   _____
   _____
4. Are you allergic to any of the following: ☐ Penicillin ☐ Food Allergies: _____
   ☐ Latex ☐ Other Allergies: _____
5. WOMEN ONLY: Are you pregnant? (Or do you think you may be pregnant?) ☐ Yes ☐ No
   If yes, what trimester/how far? _____ Expected Delivery Date: _____

Has your physician ever informed you that you have or had….? (Please select yes or no)

Heart Attack When?	☐Yes No☐	Artificial Joints/valves When?	☐Yes No☐	Stroke When?	☐Yes No☐
Heart Ailment	☐Yes No☐	Glaucoma	☐Yes No☐	Kidney Disease	☐Yes No☐
High Blood Pressure	☐Yes No☐	Respiratory Disease	☐Yes No☐	Chemotherapy/Radiation	☐Yes No☐
Mitral Valve Prolapse	☐Yes No☐	Tuberculosis	☐Yes No☐	Tumors or Growths	☐Yes No☐
Rheumatic Fever	☐Yes No☐	Asthma	☐Yes No☐	Herpes	☐Yes No☐
Diabetes (Type)	☐Yes No☐	Thyroid Disease (Type)	☐Yes No☐	Hepatitis (Type)	☐Yes No☐
Blood Disease	☐Yes No☐	Osteoporosis	☐Yes No☐	Venereal Disease	☐Yes No☐
Prolonged Bleeding	☐Yes No☐	Rheumatism or arthritis	☐Yes No☐	HIV/AIDS	☐Yes No☐
Blood Thinners	☐Yes No☐	Ulcers/Intestinal Disease	☐Yes No☐	Alcoholism/Drug Addiction	☐Yes No☐
Epilepsy	☐Yes No☐	Liver Disease	☐Yes No☐		

Please list any other medical conditions that are not listed above: _____

1. Are you currently having any dental problems? ☐ Yes ☐ No
   If yes, please state all dental problems: _____
2. What are your dental concerns? *(✓ as many as applicable)*
   ☐ Pain Avoidance ☐ Appearance ☐ Losing Teeth ☐ Your General Health ☐ Routine Checkup
   ☐ Cavities ☐ Oral Cancer ☐ Cleaning ☐ Gum/Periodontal Disease ☐ Dental Insurance Limits
3. Have you ever had a reaction to any anesthetic (either local or general)? ☐ Yes ☐ No
   If yes, please list the anesthetic: _____
4. Have you ever had abnormal bleeding following a cut or extraction? ☐ Yes ☐ No
5. What is the date of your last dental examination? _____
6. Do you have any concerns you wish to discuss privately with the doctor? ☐ Yes ☐ No
   If yes, do you wish to do so before treatment? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, dental insurance, or other account changes, I will inform this office at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You may refuse to sign this acknowledgement."

I,_____have been informed of this office's Notice of Privacy Practices.
Print Name

_____
Signature

_____
Date

FOR OFFICE USE

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)

_____
_____
_____

Barras
FAMILY DENTISTRY
1700 KALISTE SALOOM, BLDG 4 | LAFAYETTE, LA 70508
337.235.3395

APPOINTMENT SCHEDULING POLICY

For accounts that have **2** missed/failed appointments* or last minute cancellations**, we will require a minimum scheduling fee of $40. *Any appointments that are reserved for longer than 60 minutes will require an additional $20 scheduling fee per half hour of time needed for that appointment*. This fee will need to be paid in full prior to the missed/cancelled appointment being rescheduled.

If the patient attends the rescheduled appointment, the scheduling fee will be applied toward that appointment. However, if the rescheduled appointment is missed or last minute cancelled for any reason, the previous scheduling fee will be forfeited and an additional scheduling fee will be required to reschedule the missed/cancelled appointment.

Please note scheduling fees will not be filed to or paid by any insurance company.

For those patients that continue to miss/last minute cancel appointments, we will identify your family account as having chronic scheduling issues.

CHRONIC SCHEDULING ISSUES

For accounts that have been required to pay a scheduling fee and continue to miss/last minute cancel appointments, the family account will be identified as a *Chronic Scheduling Account*. These accounts will require a scheduling fee to be paid prior to scheduling all appointments. The scheduling fee will be applied toward the appointments attended but will be forfeited for appointments that are not attended.

**Missed/failed appointment*: Appointments are considered "missed" or "failed" when the patient arrives 15 or more minutes past the scheduled appointment time and the schedule does not permit the patient to be seen. If the appointment is unattended it will be considered missed/failed regardless if that visit was or was not confirmed.

***Last minute cancellation*: Appointments are considered as a "last minute cancellation" when the planned appointment is canceled by email, voicemail, text message, or by direct contact with office personnel less than **48 hours** OR **2 business days** prior to a scheduled appointment. Business days are Monday through Friday and do not include Saturday, Sunday or major holidays.

Signing below means that I have reviewed and understand Barras Family Dentistry's APPOINTMENT SCHEDULING POLICY.

Self-I am the patient.

_____	_____	_____
Signature	Relationship to patient	Date

Barras Family Dentistry, LLC.

Consent for Dental Treatment and Acknowledgement of Receipt of Information

State Law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you need. Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms the contemplated dental treatment is:

Hygiene: prophy (cleaning), exams, x-rays, full mouth debridement, scaling and root planning,

Operative: crown, onlay, inlay, bridge preps; occlusal adjustments, splint adjustments, fillings.

I understand dentistry is not an exact science and complications may occur despite our best efforts. There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

- Sensitivity to temperature (hot/cold)
- Damage to or possible loss of filings or other dental work
- Change in bite
- Damage, fracture or possible loss of the tooth/teeth being treated as well as adjacent teeth and bone
- Loss of tooth/teeth or loss of bone
- Incomplete removal of tooth
- Failure of wound to heal
- Dry socket
- Injuries to adjacent teeth and/or soft tissue
- Paresthesia or numbness of: tongue, and/or mouth, and/or face
- Injury to adjacent structures
- Fracture of mandible (upper jaw) or maxilla (lower jaw)
- Instrument breakage
- Opening between mouth and sinus or mouth and nose
- Allergic reaction to drugs
- Sloughing (unanticipated loss of hard and/or soft tissue)
- Bacterial Endocarditis
- Swallowing and/or aspiration of prosthesis and other objects
- Failure or treatment to accomplish its purpose
- Breakage or root(s) and retained root fragments
- Truisms (jaw pain or difficulty opening mouth)
- TMJ dysfunction or worsening of TMJ condition
- Additional surgery, hospitalization and/or further treatment may be required in the event of any complication(s)
- Injury from airborne particles or instruments
- Infection
- Burns from chemical agents used in treatment or dental treatments
- Bleeding
- Loss of or damage to the ability to taste, speak, hear and/or see
- Tooth or fragment in maxillary sinus
- Death

State Law also requires that I specifically advise you, although rarely occurring, the dental treatment or anesthetic may result in: Paraplegia (paralysis of both legs); Quadriplegia (paralysis of both arms and legs); Loss or loss of function of an organ(s) or limb(s); Brain Damage; or Death.

Acknowledgment

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction. I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

_____ _____

Signature of Patient or Guardian **Date**

BARRAS FAMILY DENTISTRY

FINANCIAL POLICY AGREEMENT & AUTHORIZATION FOR RELEASE OF INFORMATION

Thank you for choosing Barras Family Dentistry, as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is our Financial Policy and Agreement that we require that you read and sign before any treatment.

All new patients must complete our "Patient Information Sheet" and "Patient History Sheet" before seeing the doctor.

General Payment Requirements – Unless other arrangements are approved, ***FULL PAYMENT IS DUE AT THE TIME OF SERVICE****. We accept cash, checks, and credit cards. If payment in full creates a hardship, ask to speak with the manager to discuss other payment options.*
If for some reason your out-of-pocket payment was too much, we will refund the overpayment to you.

Regarding Insurance – This office will file on your behalf insurance claims for dental procedures upon receipt of necessary insurance information. This is a service that we provide, but please remember that you will be ultimately responsible if your insurer does not pay in full or any at all.

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You will be responsible for payment of the difference between the insurer's determination of what we should be paid and our billed charges. If your insurance company denies payment of services provided or does not pay for all services billed, you will be responsible for the balance.

Past Due Accounts – Open accounts with no acceptable* payment activity for 60 days will be considered past due. A billing charge may be assessed to the account balance along with a finance charge of 1.5% per month. You will be responsible for the original past due balance along with these additional charges.

NSF checks (non-sufficient funds) will assume a $25.00 fee from this office. The patient is responsible for all other billing charges, account fees, bank fees and collection fees associated with the bad check.

Collections – Open accounts with no acceptable* payment activity for 90 days may be automatically placed with our collection agency**. If this action becomes necessary, you will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees, late fees, and/or attorney fees and expenses incurred in collecting amount owed.** ***(Typical Late fee: 38% of balance owed is added to the outstanding balance)***

(*Acceptable payment on an account will be determined on an individual basis. Please contact the Manager if you intend to make payments on your account. This will avoid any misunderstandings.)

Assignment of Benefits and Rights – If you have dental insurance coverage, your signature of this document evidences your agreement to irrevocably assign and transfer all right, title and interest in any benefits, for our services, payable under such programs to Barras Family Dentistry. You agree to authorize and direct that any such payments be made directly to Barras Family Dentistry. You further agree to irrevocably assign and transfer to Barras Family Dentistry, the right to pursue administrative appeals of denials of claims for benefits and to assist legal claims or causes of action that may arise against your insurer or health plan for the wrongful denial of claims for benefits. This transfer and assignment shall be for the sole purpose of granting Barras Family Dentistry, the independent right of recovery against your insurer or health plan, but shall not be construed as creating an obligation to exercise such rights.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Barras Family Dentistry to release dental information and supporting documentation contained in my dental records maintained in this office to any entity that may be financially responsible for payment of expenses related to my treatment, including my insurer, and any external professional review organization acting on their behalf, for the purpose of administrating benefits under such plans. If my treatment is work-related, I authorize Barras Family Dentistry, to release medical information regarding such treatment to my employer and/or its designee. I authorize Barras Family Dentistry, to release medical records to the applicable above – listed entities that may require medical record review pursuant to a quality improvement program.

This authorization specifically includes the release of medical information concerning substance use or abuse, nervous and mental disorders and infectious diseases.

I authorize Barras Family Dentistry, to release medical records and reports to any health care provider participating in the care rendered by Barras Family Dentistry, including but not limited to referring dental practitioners, and other health care providers.

I certify that I was informed of the Notice of Privacy Practices and that I am able to receive a copy of this notice at my request.

I CERTIFY THAT I HAVE READ THE FOREGOING FINANCIAL POLICY AGREEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION AND THAT I UNDERSTAND THE PROVISIONS THEREIN.

_____
Name of Patient (Please Print)

_____
Signature of Responsible Party

Self-I am the patient.

_____
Relationship to Patient

_____
Date