Billy F Booty DDS
Vincent Leggio DDS
1962 O' Neal Lane Suite A & B
Baton Rouge, LA 70816

Patient Information

Please Print Chart # _____

Circle one: Dr./Mr./ Mrs./Ms./Miss

First: _____Middle: _____Last: _____Jr./Sr.: _____

Address: _____Apt#:____City: _____State: _____Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email Address: _____

Patient Social Security Number:_____Date of Birth: _____

Sex: (circle) **M F** Status: (Circle) **Single Married Widowed Child**

Responsible Party: _____Phone: _____Relation_____

Emergency Contact: _____Phone: _____Realation_____

How did you hear about our office? (circle one)

Radio Television Phonebook Mailer Other: _____

Internet: If so please circle which search engine: Google Bing Yahoo

Existing Patient: _____

Insurance Information

Do you have dental insurance? (circle) **YES NO**

	Primary Insurance	**Secondary Insurance**
Subscriber Name		Subscriber Name
Subscriber SSN		Subscriber SSN
Date of Birth	Date of Birth	
Relationship to Subscriber		Self Spouse Child Other Relationship
to Subscriber Self Spouse		Child other
Employer Name		Employer Name
Employer Phone		Employer Phone
Insurance Company		Insurance Company
Insurance Group #		Insurance Group #
Insurance Phone #		Insurance Phone #

- Please present insurance card to receptionist to be photocopied.

Health Information

Physician's Name & Phone Number: _____

Reason for today's visit: _____

Date of last Dental visit: _____Date of last dental x-rays:

_____

Why did you leave your last dentist:

_____

What treatment would you like to have completed today?

_____

Have you ever had any of the following dental treatment?	**Y**	**N**		**Y**	**N**		**Y**	**N**
Extraction/Date_____			Crowns/Bridges			Costmetic Whitening		
Root Canal/Endodontics			Partial Dentures			Veneers		
Fillings			Complete Dentures			Orthodontics		
Gum/Periodontal Surgery			Implants			Other_____		

For any existing crowns, bridges, partial, dentures, How old are they?

_____

How Frequently do you brush your teeth?_____Floss your teeth?

_____

How often do you visit the dentist?

_____

Health Information - Continued

Do you have history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Epilepsy/Seziures/ Date_____			Psychiatric Disorder			Joint Replacement		
Chemical dependency			Recurrent Bronchitis			Stomach/intestinal Disease		
High Blood pressure			Pneumonia			Skin Disorders		
Heart Surgery/ Date_____			Tuberculosis			Diabetes		
Heart Attack/ Date_____			Hepatitis (type A, B, C)			Anemia/ Hemophilia		
Stroke/ Date_____			Kidney Failure			Veneral Disease		
Chest Pains/ Angina			HIV/AIDS			Asthma		
Congenital Heart Disease			Kidney Stones			Cancer		
Thyroid Problems			Osteoporosis			Mitral Valve Prolapse		
Pacemaker_____ _			Other_____					

ALLERGIES-Please circle: Penicillin Aspirin Codeine latex None Other_____

Do you smoke? **YES/ NO** Packs per day?_____Do you drink alcoholic beverages? **Yes/ No** Drinks per week?_____

LADIES ONLY: Are you pregnant?_____If so, what month?_____

List All medications you are currently taking?

_____

_____

_____

_____

Consent for Dental Treatment and Acknowledgement of Receipt of Information

State law requires us to obtain your consent for the contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be please to explain.

I hereby authorize and direct **Denture Plus of LA** doctors, assistants, hygienist, and specialist of their choice to perform upon me the following dental procedures:

Photographs, radiographs, study models, extractions, and other surgical procedure, biopsies, periodontal cleaning and/or surgery, root canals, partials, and/or complete dentures, crowns, bridges, bleaching and tooth lightening procedures, porcelain and resin veneers, lumineers, and splints including any necessary or advisable anesthesia.

ALTERNITAVES TO THE RECOMMENDED DENTAL TREATMENT:
Alternatives to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

RISK ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:
I understand that dentistry is not an exact science and that complications may occur despite our best efforts. Partial listings of the risk known to be associated with this treatment and with the associated anesthetic are: **Swelling and bruising, which may necessitate staying home for a few days. Bleeding, sometime prolonged enough to necessitate additional services to cause it to cease. Instrument breakage and/or retained instrument fragment(s). Breakage of roots and/or retained root fragments. Parasthesia – permanent or temporary numbness of the cheek, gums, teeth, lips, tongue, chin, and face. Loss of taste, loss/damage to adjacent teeth and bone, fracture jaw, sinus involvement, change in the bite, TMJ Dysfunction or worsening of TMJ condition. Trismus (jaw pain or difficulty opening the mouth). Swallowing/aspiration of objects, infection/dry socket, pain, drug/allergic reaction, stretching of the mouth, which may cause bruising or result in cracking. Failure of the treatment to accomplish its purpose, further surgery and/or treatment.**

USE OF ILLICIT DRUGS:
The use of illicit or street drugs can adversely affect treatment, including anesthesia and sedation, possibly resulting in death. Please notify the doctor if you have used any drugs within the last 24 hours. State law also requires that I specifically advise you that, although rarely occurring, the dental treatment of anesthetic may result in death, brain damage, quadriplegia, paraplegia, loss of organ(s), loss of function of an organ(s), loss of function of the face, arm(s), or leg(s), and disfiguring scars.

Photographs:
I hereby specifically authorize the above doctors and staff to take, develop and use photographs at all phases of my treatment for educational, demonstrative and/or promotional purposes specifically including use in lectures and publication and I do hereby forever waive any claim to royalties or other monies or other sources of reimbursement that are received from their use.

Acknowledgement
I acknowledge that I have read and I understand the information on both pages of this consent form (or that is has been read to me). I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of this treatment and the avoidance of treatment complications depend to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me and my keeping appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s), where further treatment may be discussed, or administered, which is not currently anticipated.

I hereby authorize **Denture Plus of LA** dentist, hygienists, specialist or assistants of their choice to preform diagnostic, surgical or dental treatments. This consent form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive further disclosures or information

_____	_____	_____
Patient Signature	Signature of Parent or Gaurdian	Date

Privacy Agreement

Drs. Billy F Booty DDS, Associates and Staff (hereinafter collectively referred to as “We” and “Dentists”) agree to maintain the privacy of their patient as outlined in this HIPAA form. We take great care in being able to extend a higher level of privacy than is required by HIPAA, state confidentiality law and common law.

Due to complex nature of State and Federal Privacy laws it has come to our attention that some dental offices are able to work around these laws. An example: Under HIPAA a dentist is not allowed to receive money for selling patient lists or protected health information to companies to market their products or services directly to patient without authorization. It is our understanding that there are dental practices the lawfully circumvent this limitation by allowing a third party to market the information. It is important to note that personal data is not in the possession of the company selling it products or services, but the patient may still receive unwanted solicitation. We do not agree with this manner of marketing and furthermore, we do not think it is in our patients’ best interest. Therefore, we agree not to provide any list for marketing or to accept any payment for patient list or protected health information to any third party for the purpose of marketing to our patient.

In consideration for treatment and the above additional protection of patient’s privacy, Patient agrees to refrain from directly or indirectly publishing commentary that would reasonably be considered negative to the doctor, the practice and/or the Doctor’s Associates and Staff unless such commentary is explicitly required by law. We have invested a significant amount of resources in the development of our practice through our time, money and marketing and ask that you not defame, disparage or discuss the doctor, the associates, the staff or our practice in a negative manner as it will cause serious damage to our practice.

We are adamant about our patients’ privacy as well as the practices’ right to control its public image and privacy. Dentist and you agree to work together to prevent publishing or broadcasting of commentary about the other party from being assessed in any media. This Agreement will be inforce and enforceable for a period of the longer of (a) five years from our last date of service to the patient; or (b) three years beyond any termination of the Dentist-Patient relationship. As a matter of office policy, we are requiring all patients in our practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all our patients.

You, as the patient and we acknowledge that breach of this agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, both the Patient and Dentist agree to the right of equitable relief, including, injunctive relief and beyond. Should a breach of this Agreement result in litigation, the prevailing party in the litigation will be entitled to reasonable cost, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive explanations to their satisfaction.

Patient Signature_____Date_____

I authorize **Denture Plus of LA** to disclose and discuss any information involving my treatment and/or medical records to the following:

Name_____Relationship_____

Name_____Relationship_____

Financial Arrangement Agreement

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

In order to be impartial to everyone, WE REQUIRE PAYMENT AT THE TIME OF TREATMENT. We ask that you read and sign this statement prior to any treatment. YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF THE TREATMENT. We accept cash, Visa, MasterCard, Discover Card, and American Express. WE DO NOT ACCEPT CHECKS.
For extensive treatment plans, we offer extended payment plans with CareCredit at either little or no interest with prior credit approval, and Icare with no credit check and a 30% down payment.

Acknowledgement
I hereby certify that the medical and dental history provided is correct to the best of my knowledge and give my consent for the doctors and staff at Denture Plus of LA to treat my dental needs based on this information.

Missed Appointments
In order to be fair to all of our patients, we ask that you notify our office at least 48 hours in advance if you cannot keep your scheduled appointment. Our policy for any missed appointments is a charge of a normal office visit.

Warranty
Denture Plus of LA warranties all dental treatment. Composite fillings, Dentures and Partials needing to be replaced have a 1 year warranty from original date of service. Crowns, Veneers and Bridges needing to be repaired have a 2 year warranty from the original date of service. At no time will a refund be given for dental treatment.

Regarding Insurance
I, the undersigned patient, understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

As a courtesy, our office will file claims to your insurance; however, your insurance is a contract between you and your insurance company. Insurance companies frequently reimburse at a lower rate than we estimate. When this occurs, you may be required to pay an additional “after insurance” balance.

I authorize Denture Plus of LA to release any dental information necessary to process dental insurance claims. I also request and authorize payments of any benefits, applicable to services rendered, to Denture Plus of LA.

Finance Charges
Be aware that any unpaid balance after 60 days is charges a yearly finance charge of 18% and that is finance chargeis equal to 1.5% of the outstanding balance per month. If the account reaches collections status and no effort is made to pay it off, the account will be assigned to a collection attorney or agency. If the doctor must take addition steps to collect the account, all cost of collection including court cost and attorney’s fees incurred by the doctor will be charged to the patient.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Patient
Signature_____Date_____