We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? ______________________________

About You

Name: ____________________ I prefer to be called: ____________________ ☐ Male ☐ Female

Birth Date: ____/____/____ Age: ______ Social Security #: ______-____-______

☐ Single ☐ Married ☐ Child ☐ Other Email: ____________________

Home Address: ____________________ City: ____________________ State: ________ Zip: __________

Home Phone: ____________________ Cell: ____________________

Employer: ____________________ How long there? __________ Occupation: ____________________

Employer's Address: ____________________ City: ____________________ State: ________ Zip: __________

Work Phone: ____________________ Ext: ____________

Responsible Party

☐ Same as above Name: ____________________ Birth Date: ____/____/____

Relation: ______________ Home Phone: ____________________ Social Security #: ______-____-______

Billing Address: ____________________ City: ____________________ State: ________ Zip: __________

Employer: ____________________ How long there? __________ Occupation: ____________________

Employer's Address: ____________________ City: ____________________ State: ________ Zip: __________

Work Phone: ____________________ Ext: ____________

Spouse Information

Name: ______________________________ Birth Date: ____/____/____

Employer: ______________________________ Work Phone: ______________ Ext: ________

Emergency Contact

Emergency Contact (not living with you): ______________________________ Relation: ______________

Home Phone: ____________________ Work: ____________________ Cell: ____________________

Stephanie G. Babin, DDS | Randall J. Babin Jr., DDS

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Dental Insurance Information

Primary Insurance

Insurance: ______________________________

Phone #: ______________________________

Insured's Name: ______________ DOB: ___/___/___

Insured's SS#: ____/___/_____ Employer: ____________

Member ID #: ____________ Group/Policy #: __________

Secondary Insurance

Insurance: ______________________________

Phone #: ______________________________

Insured's Name: __________ DOB: ___/___/____

Insured's SS#: ____/___/____ Employer: ________

Member ID #: _________ Group/Policy #: ________

Patient Health Information

Dental History

What is the reason for your visit today? ______________________________

Date of Last Dental Visit: _____/______/______ Last Dental Cleaning: ______/______/______

Previous Dentist's Name: ________________________

How often do you brush your teeth? ____________ How often do you floss? ______________

Have you ever use or are currently using topical fluoride? ☐ YES ☐ NO

Are you extremely fearful of the dentist? ☐ YES ☐ NO

Has fear ever prevented you from seeking dental treatment? ☐ YES ☐ NO

Are you happy with the appearance of your smile? ☐ YES ☐ NO

Do you prefer to save your teeth? ☐ YES ☐ NO

Have you had any trouble associated with previous dental treatment? ☐ YES ☐ NO

If yes, please explain: ______________________________

Is there anything about your smile you would like to change (shape, color, alignment)? ☐ YES ☐ NO

If yes, please explain: ______________________________

Have you ever been told to take a pre-medication prior to dental treatment? ☐ YES ☐ NO

Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ☐ YES ☐ NO

Date: _____/______ If yes, were there any complications? ______________________

Circle any of the following which apply to you:

Fingernail Biting
Bad Breath
Dry Mouth
Burning Sensation on Tongue
Blisters on Lips or Mouth
Sensitivity to Cold
Sensitivity to Heat
Sensitivity to Sweets
Sensitivity when Biting

Grinding/Clinching Teeth
Chew on One Side of Mouth
Pain around Ear
Clicking/Popping Jaw
Jaw Pain or Tiredness
TMJ Treatment
Injury to Face, Jaw, or Teeth
Bleeding Gums
Gums Swollen/Tender

Food Collection Between Teeth
Lumps or Sores in Mouth
Periodontal (Gum) Treatment
Loose Teeth
Broken Fillings/Teeth
Cigarette, Pipe, or Cigar Smoking
Lip or Cheek Biting
Orthodontic Treatment

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Medical History

Are you in good health? ☐ YES ☐ NO

Are you currently under the care of a health physician? ☐ YES ☐ NO

If so, for what condition? ______________________________

My last physical exam was on (approximately): _____/_______/_______

Have you had any serious illness, operative or hospitalization within the past 5 years? ☐ YES ☐ NO

Please list your family physician and any medical specialists you see at least once a year:

Name	Specialty	Phone Number

Please list all medications you are currently taking including diet pills, over-the-counter medicines, vitamins, homeopathic natural remedies, herbal medications, or dietary supplements: ______________________________

Circle any of the following which apply in either the PAST or PRESENT:

Mitral Valve Prolapse
Heart Failure
Heart Disease or Attack
Family History of Cardiac Disease
Bacterial Endocarditis
Congestive Heart Failure
Irregular Heart Beat/Heart Murmur
Family Cardiovascular Disease
Angina Pectoris (Chest Pain)
Rheumatic Fever/Heart Disease
Congenital (at birth) Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
High Blood Pressure
Low Blood Pressure
Anemia
Stroke
Sickle Cell Disease
Bruise Easily
Blood Transfusion
Hemophilia
Bleeding problems or blood disease

Emphysema or Bronchitis
Shortness of Breath
Smoke or Use Smokeless Tobacco
Asthma
Diabetes (Type I or Type II)
Spleen Removal
Kidney Disease
Thyroid Disease
Liver Disease
Tuberculosis
Hepatitis (A, B, C or D)
Other Liver Disease
Ulcers, Stomach/Intestinal Disease
Steroid Therapy
Lupus (SLE)
Rheumatism
Muscle or Joint Disease
Cortisone Medication
Rheumatoid Arthritis
Osteoarthritis
Artificial Joints
Other Artificial implants/devices
Organ Transplant
Nervous System Disease

Fainting or Dizzy Spells
Epilepsy or Seizures
Nervousness
Psychiatric Treatment
Eating Disorder
Cold Sores or Fever Blisters
Genital Herpes
Cancer or Tumors
Chemotherapy
Radiation or Cobalt Treatment
HIV or AIDS
Long term (> 1 month) antibiotic use
Glaucoma
Impairment of Hearing
Impairment of Sight
Impairment of Speech
Undiagnosed Symptoms
Allergies, Hay Fever or Sinus Trouble
Recreational Drug Use
Drug Addiction/Alcoholism

Do you have any disease, condition or problem not listed? If so please list: ______________________________

Women

Are you pregnant or think you could be pregnant? ☐ YES _________ Months ☐ NO

Nursing? ☐ YES ☐ NO

Do you use birth control prescriptions? ☐ YES ☐ NO **Antibiotic use lowers effectiveness of birth control.**

Circle any of the following you are allergic to or have had a reaction to:

Local Anesthetics
Penicillin or Other Antibiotics
Latex (Rubber)
Sulpha Drugs
Aspirin
Metals
Iodine
Other: ___________________________

☐ YES ☐ NO Have you ever taken any bisphosphonate medications such as alendronate (Fosamax), risedronate (Actonel), or Bonita for osteoporosis or Paget's disease?

☐ YES ☐ NO Have you ever been treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

☐ YES ☐ NO Have you been a patient in the hospital during the past 2 years?
If yes, please list: ____

☐ YES ☐ NO Have you lost or gained more than 10 pounds in the last year?

☐ YES ☐ NO Do you use more than 2 pillows to sleep?

☐ YES ☐ NO Do you ever wake up from sleep short of breath?

☐ YES ☐ NO Have you ever had excessive bleeding requiring special treatment?

Babin Dental LLC requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside the practice will be provided with this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in our practice being unable to accept you as a patient. By signing below, you agree that the information given is accurate and that you will notify our office at subsequent appointments if there are any changes in your health.

____

Patient's (or Legal Guardian's) Signature Date

Initial _________ If you should need restorative treatment, we require a $50 deposit to reserve you spot on the operative schedule. This will be applied towards your portion of treatment. Thank you!

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NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that I may ask any questions I might have regarding this notice.

Printed Named: ____ Date: ___________________

Signature: ____ Date: ___________________

FOR OFFICE USE ONLY

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

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (please specify): ____

Insurance Authorization/Assignment

I hereby authorize Babin Dental LLC to furnish to my insurance carriers any information necessary to process any claim for services rendered by either Drs. Babin. I hereby assign to these same dentists any insurance benefits payable for services rendered to my dependents, or myself but not to exceed my indebtedness to Babin Dental LLC. I understand I am financially responsible for all services rendered regardless of insurance coverage.

____

Patient's (or Legal Guardian's) Signature   Date

Appointments

We value your time so you can expect us to see you at the appointed occasion and to keep your period spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patient and our practice. Missed appointment will result in a $25.00 fee. We value your time. Please value ours.

Initial ________

Financial Policy

Dental insurance plans often pay less than the actual fee for service, therefore the patient or guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Treatment Discussion appointment. Your estimated patient option is only an approximation and is based on your estimated insurance benefits. We are NOT responsible for any agreement between you and your insurance company. As a courtesy to you, we will be happy to file with your insurance company. To keep our fees to you as low as possible, we ask that you pay your ESTIMATED copayment at the time you receive treatment. Also, we do not downgrade fees or insurance code changes (any difference in fee will be your responsibility). We allow 45 days for your insurance to pay and then you, the responsible party, will be required to pay any remaining balance.

Initial ________

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment, or on pre-op visits for sedation appointments. If a procedure requires multiple appointments, payment is required in full at the first appointment. Should a patient have dental insurance with assignment to Babin Dental LLC, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full. Should it become necessary any attorney fees, court costs, and collection fees become my responsibility and will be added to my account.

Initial ________

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex, and Discover.
2. You can also apply for a financing option at our office with Care Credit with a monthly payment plan that is interest free for a year. You can select the payment date that works best for your budget.

Release of Information

Initial ________ I authorize Babin Dental LLC to release any information regarding my dental or medical history, diagnosis or treatment to the third party payers and/or health professionals.

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