Patient Registration Information
Confidential

Welcome to our practice!

Thank you for selecting our dental healthcare team. **PLEASE FILL OUT ALL INFORMATION.** If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help!

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Date_____

Name_____
First Mi Last

Address_____ City_____ State____ Zip_____

Home#_____ Work#_____ Cell#_____

Email_____ Preferred contact: Home Work Cell Email

Date of Birth _____ SSN_____ Driver's License #_____

Employer/School_____

Are you: Minor Single Married Divorced Widowed Separated

How did you hear about us?

Google Facebook Friend/Family Member Other Name of person/other: _____

Person to contact in case of an emergency_____ Phone #_____

Please provide us with the name and phone number of a contact person that we can call if we are unable to reach you to confirm your appointment.

Name of contact person_____ Phone number of contact person_____

Dental Insurance Provider _____ Member ID_____ Group ID_____

Responsible Party/Policy Holder Information if other than self: Parent Spouse

Is this person currently a patient in our office? Yes No

Name/Relationship_____

Address _____

Date of Birth_____ Social Security #_____ Driver's Lic#_____

Employer_____ Work #_____ Home#_____ Cell#_____

Over →
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Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

Late Charges

All unpaid balances 30 days or older will be assessed a late fee of 1.5% each month. I understand that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies. If additional services are needed, prepayment may be required prior to scheduling. In the event of default on payment of this account, I agree to pay all collection costs and all attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Further, I agree that the construction and interpretation of this document shall at all times and in all respects be governed by the laws of the State of Louisiana. Any dispute arising out of this document, or any sales or services of the clinic, including the collection of any unpaid fees and enforcement of any judgement, may be litigated and/or enforced in the 2nd Justice Court, Parish of Ascension, State of Louisiana, and I do hereby personally consent to the jurisdiction and venue of said court.

I verify that the preceding information is true. I authorize the release of information to my insurance company. I will allow Dr. Bailey and his associates to discuss my condition with my physician and to request medical information from him. I authorize the office of Gray Bailey, DDS or his agent to obtain and verify a credit report.

_____ _____

Signature of Responsible Party Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

Patient Name _____ **Date of Birth** _____

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

(Please place an X in the box which applies)

	X
1. Are you under medical treatment now?	
2. Have you ever been hospitalized for any surgical operation or serious illness?	
3. Are you taking any medications, including non-prescription medicine? If yes, what medications are you taking? _____ _____ _____	
4. Do you use Tobacco? Packs a day? _____	
5. Do you use alcohol, cocaine or other drugs?	

6. Are you allergic to or have you had any reactions to the following?

X (Please place an x in the box which applies)

- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Sedatives

7. Other food or drug allergies? If so, what?

_____

_____

8. Women Only:

	X
a) Are you pregnant or think you may be pregnant?	
b) Are you nursing?	
c) Are you taking birth control?	

9. Preferred Pharmacy: _____

10. Do you have or have you had any of the following? (Please place an X in the box which applies)

X		X		X		**COMMENTS**
☐	**High/Low Blood Pressure**	☐	**Frequently Tired**	☐	**Hepatitis**	
☐	**Heart Attack**	☐	**COPD**	☐	**Jaundice**	
☐	**Heart Disease**	☐	**Tuberculosis**	☐	**Thyroid Problem**	
☐	**Cardiac Pacemaker**	☐	**Respiratory Problems**	☐	**Swollen Ankles**	
☐	**Angina**	☐	**Fainting/Seizures**	☐	**Arthritis**	
☐	**Chest Pains**	☐	**Epilepsy/Convulsions**	☐	**Joint Replacement or Implant**	
☐	**Stroke**	☐	**Diabetes**	☐	**Sexually Transmitted Disease**	
☐	**Anemia**	☐	**Kidney Disease**	☐	**Stomach Troubles/Ulcers**	
☐	**Asthma**	☐	**Cancer**	☐	**Glaucoma**	
☐	**Emphysema**	☐	**Radiation Therapy**	☐	**Sleep Apnea**	
☐	**Easily Winded**	☐	**Liver Disease**	☐	**Other** _____	

Patient Dental History

	X
1. Do your **gums bleed** while brushing or flossing?	
2. Are your **teeth sensitive** to **hot** or **cold** liquids/foods?	
3. Are your **teeth sensitive** to **sweet** or **sour** liquids/foods?	
4. Do you feel **pain** in any of your **teeth**?	
5. Do you have any **sores** or **lumps** in or near your **mouth**?	
6. Have you had any **head**, **neck** or **jaw injuries**?	
7. Do you have any of the following problems with your **jaw**? a) **Clicking**? b) **Pain** (joint, ear, side of face)? c) Difficulty in **opening** or **closing**? d) Difficulty in **chewing**?	

	X
8. Do you have frequent **headaches**?	
9. Do you **clench** or grind your teeth?	
10. Do you bite your **lips** or **cheeks** frequently?	
11. Have you ever had any **difficult extractions** in the past?	
12. Have you ever worn **braces**?	
13. Have you ever had **prolonged bleeding** following extractions?	
14. Have you ever had **instructions on brushing** your teeth?	
15. Have you ever had i**nstructions** on the care of you **gums**?	

Is there anything you would like to change about your mouth or smile? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: X_____ **Date:** _____

(Patient, Parent or Guardian)

Over →

Absolute Quality Care Dentistry
Gray A. Bailey, D.D.S
38384 Highway 42
Prairieville, Louisiana 70769
(225)673-9535

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 do not understand.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms the contemplated dental treatment:

All aspects of general dentistry, as needed.

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 premedication prior to dental care being rendered. Some of these risks/complications are, but are not limited to the following:

Infection

Injuries to adjacent teeth and/or hard or soft tissue

Bleeding

Failure of wound to heal

Dry socket

Loss of teeth

Incomplete removal of tooth

Loss of bone

Injury to adjacent structures

Instrument breakage

Allergic reaction to drugs

Bacterial endocarditis

Tooth or fragment in maxillary sinus

Breakage of root(s)

Death (in rare instances)

Retained root fragments

Swallowing and/or aspiration of objects

Failure of treatment to accomplish its purpose

Trismus (jaw pain or difficulty opening mouth)

Paresthesia or numbness of tongue, and/or mouth, and/or face

Fracture of mandible (lower jaw) or maxilla (upper jaw)

Slough (unanticipated loss of hard and/or soft tissue)

Opening between mouth and sinus or mouth and nose

Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s).

Acknowledgement
I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given adequate opportunity to ask 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 unless revoked by me in writ

_____ _____

Date **Signature of Patient or Guardian**

Absolute Quality Care Family Dentistry
Gray A. Bailey D.D.S
38384 Highway 42
Prairieville, Louisiana 70769
(225) 673-9535

Financial Options for Our Patients

Please Read Carefully.

We are here to discuss any questions you may have.

Please circle your options of payment and sign below:

- € ___**Default option: Pay at the time services are rendered**. 100% of payment is due at time of service. If your case requires a dental lab, will we accept 50% now and 50% at delivery on the lab case portion of your appointment.

Save $$$ on your future visits by:

- € ___**Pre-payment:** Save 7% by prepaying with cash or check for your next visit at the time. Save 4% today by prepaying with a Credit Card/Debit Card for your next visit. **To qualify for this discount, you must prepay at the end of todays visit when you schedule your next appointment.** (No out of town checks. No Trade Dollars.)

Finance Options: Financing allows you to start your dental treatment immediately and spread the payments over a period of time. Most importantly, you enjoy the benefits of your dental health without the financial strain.

- € ___**Compassionate Healthcare Services:** We provide outside financing with a 20% down payment. **Amount financed must be $1800.00 or more.** Please ask for an application. This option is for patients who are unable to get Care Credit. **You must have an active checking account.**

- € ___**Community Acceptance:** For services up to $2500. Fill out application and they will finance with reasonable interest and payment options.

Patients with insurance to include the insurance benefit signed agreement:

- € ___**Pay 100% the day of service and file insurance and have insurance pay subscriber.**

- € ___**Pay your estimated portion and e-File insurance to pay Dr. Bailey. Then Charge your credit card in vault for the balance 30 days from date of service.**

Patients with no insurance:

- € ____**AQDP MEMBERSHIP:** Join **AQDP** today and start saving today. No yearly Maximum. No insurance forms to fill out. This option is only for **patients without dental insurance**. **AQDP IS THE BEST OPTION FOR SAVING** you/your family money to maintain your dental health. For this option, we accept Cash / Check / Credit Card only.

_____ _____
Patient Signature/Responsible Party Date

_____ _____
Team Member Date

Revised 10/19/2021

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Appointment Policy

When an appointment is made with our office, we have reserved time just for you. We do our best to see you on time and we ask that you arrive on time. We will **always** make time for emergencies and we may run behind schedule. Please understand, you may also have an emergency down the road in which case, you will be our first priority. If this happens, our staff will keep you informed as to how soon we will be able to see you. Your patience is appreciated.

Broken Appointments

The most costly appointment is a missed appointment. When an appointment is scheduled with our office, we have reserved a specific amount of time especially for you. A dental room is set up for your specific dental needs before you arrive. We are prepared with the team members to assist and provide for your dental services. We value your time and we ask that you value our time.

If you fail to give our office 48 hour notice to cancel or reschedule your appointment, we reserve the right to charge you $100 per hour for the time reserved on our schedule.

Your dental health is important to us. Our goal is to keep you healthy. What we really want is for you to make every appointment so we can help keep you healthy.

Your signature below indicates that we must have a mutual respect for each other's time.

_____ Date_____

Over →

Absolute Quality Care Family Dentistry

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

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):
