THANK YOU FOR CHOOSING OUR OFFICE TO TAKE CARE OF YOUR DENTAL HEALTH.

YOU SHOULD FIND OUR STYLE OF DENTISTRY MUCH DIFFERENT THEN PAST DENTAL EXPERIENCES. DR BARRILLEAUX AND HIS STAFF ARE COMMITTED IN GIVING PERSONALIZED SERVICE WITH CUSTOMIZED DENTAL TREATMENT. TO THOSE PATIENTS WHO WANT MORE, WE WELCOME.

PATIENT INFORMATION

DATE :

(Prefers to be called)
NAME :______________________________ **LEGAL NAME :** ____________________

ADDRESS : ____

____

CITY : ____________________ **STATE :** __________ **ZIP CODE :** ____________________

PHONE : Home ____________________ Work ____________________ Cell ____________________

- ***TO SUCCESSFULLY CONFIRM YOUR APPOINTMENTS, YOU CAN BE BEST REACHED AT :***

☐ HOME TIME : ____________________

☐ WORK TIME : ____________________

BIRTHDATE : ______________ **AGE :** _______ **SEX :** ☐ Male ☐ Female

MARITAL STATIS : ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SOCIAL SECURITY NO. : ________-__________-_________

☐ **FULL TIME STUDENT ? WHERE :** ______________________________________

- **PERSON TO CONTACT IN CASE OF EMERGENCY :** NAME ______________________________
(CLOSEST RELATIVE NOT LIVING WITH YOU) PHONE ______________________________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE :

☐ None ☐ Self ☐ Spouses ☐ Childs ☐ Other

EMPLOYED BY : ______________________________

LOCATION : ______________________________

INSURANCE CO. : ______________________________

- ***Complete if insured is different from patient.***

INSURED NAME :______________________________

INSURED DOB : _____/_____/______

INSURED SSN : ______-______-_______

SECONDARY DENTAL INSURANCE :

☐ None ☐ Self ☐ Spouses ☐ Childs ☐ Other

EMPLOYED BY : ______________________________

LOCATION : ______________________________

INSURANCE CO. : ______________________________

- ***Complete if insured is different from patient.***

INSURED NAME :______________________________

INSURED DOB : _____/_____/______

INSURED SSN : ______-______-_______

- **So you can receive a closer estimation of your *patient payment*, please give the Patient Manager as much insurance information as possible. Example : yearly deductibles, yearly maximums, insurance year, insurance payment %, etc.**

ACCOUNT INFORMATION

- ***RESPONSIBLE PERSON FOR PAYMENT :***
(COMPLETE IF OTHER THAN SELF)

NAME : ______________________________

ADDRESS : ______________________________

____

CITY : ____________ STATE : _____ ZIP : ________

DRIVERS LICIENCE # : ____________________

SOCIAL SECURITY # : __________-______-__________

To verify account information and patient identification for medication prescriptions. Please allow the Patient Manager to make copies of your dental insurance card and drivers license.

CONSENT FOR TREATMENT

Modern dentistry can offer a better quality of life and piece of mind to those who choose to have dental treatment performed. However, there can be risk of complications during and/or after dental treatment. Nevertheless, the patient needs to understand there are risks.

- I hereby authorize Dr Darren Barrilleaux and/or designated staff to take x—rays, study models, photographs, and other diagnostics deemed appropriate by the doctor to make a thorough diagnosis in order to give me a complete recommendation for treatment.
- Upon such diagnosis, I authorize the doctor to perform all recommended treatment, mutually agreed upon by me, and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.
- Dr Barrilleaux and/or staff can not be held legally responsible for any complications that may arise during or after receiving dental treatment if I have **NOT** disclosed all medical and dental information to Dr Barrilleaux and staff or if I have not completely followed pre and post treatment instructions given by Dr Barrilleaux and/or staff.

FINANCIAL AGREEMENT

Dr Barrilleaux and his staff are very serious about giving excellent dental treatment and personalized service to their patients. They are also very serious about receiving payment for services performed. You can have a great dental experience and a life long dental relationship as our patient. In order to maintain a professional working relationship , the following financial exceptions must be understood and followed.

- I will pay for all dental services received when my account is charged.
- Having **DENTAL INSURANCE** is not a free ticket. It is a good benefit that helps supplement the cost of having a healthy mouth. It is my insurance, therefore, it is **MY RESPONSIBILITY** to know its limitations. Dr Barrilleaux is my dentist, not my insurance agent. If I have a balance, after my insurance company has or has not paid, I will pay it in full when I receive my statement. Further more, I will also pay the balance of my account, if my insurance company holds payment to Dr Barrilleaux longer than 30 days. If there is a discrepancy with the estimated cost to me and what my insurance company has or has not paid, I will pay in full my balance . Then I will contact my insurance company to settle the discrepancy.
- Reserved dental time is very important to you and the emergency patient in pain. Dr Barrilleaux request a **48 HR RESCHEDULING OR CANCELLATION NOTICE FOR GENERAL TREATMENT**. If I fail to keep my reserved appointment or do not give advance notice, I will be subject to pay an **OFFICE CHARGE.** Notice must be verbally communicated to the Patient Manager.
- If I **AVOID PAYMENT**, my account will be subject to additional charges for all costs of collections. **Collection costs** may include : court cost, reasonable attorney fees, credit bureau %, private investigator, etc.
- The **ONLY EXCEPTION** to the above expectations is to be approved by the PATIENT MANAGER. For a **FINANCIAL** exception to be made, an **AGREEMENT** must be written, signed and accepted or my account will become delinquent.
- **Delinquent accounts**, without a Financial Arrangement, are subject to $10.00 **LATE CHARGES** and 1.5 % (18% APR) **FINANCE CHARGES** on the unpaid balance.

I understand, accept and agree to all conditions listed above for both CONSENT FOR TREATMENT and FINANCIAL AGREEMENT.

Signature of patient or responsible party :__________________________________ **Date :** ________________

PATIENT NAME

PAGE

COPY **: DRIVERS LICIENCE**
INURANCE CARD