Chad Biggio D.D.S.
8480 Bluebonnet Blvd Ste. E
Baton Rouge, LA 70810
(225) 767-4491

PATIENT INFORMATION

Patient's Name: _____
First Middle Last

If Child: Parent or Guardian Name: _____ Relation: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Patient's Social Security #: _____ Date of Birth: _____

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

E-Mail Address: _____

Emergency Contact: _____Phone: _____ Relation: _____

How did you hear about our office? _____

INSURANCE INFORMATION

Do you have Dental Insurance? (circle) **Yes No**

Primary Insurance

Subscriber's Name: _____
Subscriber's ID or SSN: _____
Subscriber's Date of Birth: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Insurance Company: _____
Insurance Phone: _____
Group #: _____

Secondary Insurance

Subscriber's Name: _____
Subscriber's ID or SSN: _____
Subscriber's Date of Birth: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Insurance Company: _____
Insurance Phone: _____
Group #: _____

*Please present insurance card and photo id to receptionist to be photocopied. We cannot bill your insurance unless you give us your current, accurate insurance information.

PATIENT'S MEDICAL HISTORY

Physician' Name & Phone: _____ Date of Last Exam: _____

Do you or have you had any of the following:

YES / NO	Anemia / Hemophilia	YES / NO	Joint Replacement
YES / NO	Angina / Chest Pains		Date: _____
YES / NO	Anxiety / Nervous Problems	YES / NO	Kidney Disease
YES / NO	Arthritis	YES / NO	Liver Disease
YES / NO	Asthma	YES / NO	Mitral Valve Prolapse (MVP)
YES / NO	Cancer	YES / NO	Osteoporosis
YES / NO	Chemical Dependency	YES / NO	Pacemaker
YES / NO	Circulatory Problems	YES / NO	Psychiatric Care
YES / NO	Diabetes: Type I or II	YES / NO	Radiation / Chemotherapy
YES / NO	Epilepsy / Seizures	YES / NO	Respiratory Problems
YES / NO	Excessive Bleeding	YES / NO	Rheumatic Fever
YES / NO	Heart Attack	YES / NO	Stomach / Intestinal Disease
	Date: _____	YES / NO	Stroke
YES / NO	Heart Murmur		Date: _____
YES / NO	Heart Surgery	YES / NO	Thyroid Problems
	Date: _____	YES / NO	Tuberculosis
YES / NO	Hepatitis (type A B C)	YES / NO	Ulcers / Cold Sores
YES / NO	High Blood Pressure	YES / NO	Venereal Disease
YES / NO	High Cholesterol	YES / NO	Family history of Diabetes
YES / NO	HIV / AIDS	YES / NO	Family history of Heart Disease

Other: _____

ALLERGIES: Please circle all that apply: Penicillin Aspirin Codeine Latex Sulfa Anesthetics Other Allergies _____ NONE

Do you smoke? YES / NO
Packs per day? _____

Do you use alcoholic beverages? YES / NO
Drinks per week? _____

Are you pregnant? YES / NO # of weeks: _____

List all medications you are currently taking: _____

_____

Please describe any current medical treatment, impending operations or any other medical information that may possibly affect your dental treatment:

_____

_____

PATIENT'S DENTAL HISTORY:

Reason for today's visit: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

What treatment would you like to have completed? _____

Have you ever had any of the following dental treatments?

YES/NO	Extraction	YES/NO	Crowns / Bridges
YES/NO	Fillings	YES/NO	Root Canals / Endodontics
YES/NO	Complete Dentures	YES/NO	Gum / Periodontal Surgery
YES/NO	Partial Dentures	YES/NO	Implants
YES/NO	Veneers	YES/NO	Orthodontics
YES/NO	Cosmetic Whitening	YES/NO	Other _____

For any existing crowns, bridges, partials or dentures, how old are they? _____

How many times a day do you brush your teeth? _____ Floss? _____

YES / NO Do your gums bleed?
YES / NO Are your gums sore or swollen?
YES / NO Have your gums receded?
YES / NO Are your teeth loose
YES / NO Do you have unexplained numbness or pain?
Face / Neck / Mouth / Ears
YES / NO Following problems in your jaw?
Clicking / Pain
YES / NO Do you clench or grind your teeth?
YES / NO Difficulty in opening or closing
YES / NO Difficulty in chewing
YES / NO Are your teeth sensitive to hot or cold liquids or foods?
YES / NO Do you snore or have been told you snore?
YES / NO Do you have a lump or thickening in the cheek?
YES / NO Do you have a sore or lesion on the lips or mouth that has persisted for 2 weeks or more?
YES / NO Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

_____.

AUTHORIZATION AND RELEASE

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 Biggio Dental Care to treat my dental needs based on this information. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

_____ _____

Signature of Patient or Parent/Guardian if Minor Date

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 pleased to explain.

I hereby authorize and request the performance of dental services by Dr. Chad Biggio and such associates or employees he may designate, and the use of whatever procedures Dr. Biggio may deem necessary or advisable to maintain my dental health, or the dental health of any minor or other individual for which I am responsible for treatment. Any restorative treatment or therapy such as crowns, fillings and extractions will require my additional consent to treatment.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I receive.

RISK OF DENTAL PROCEDURES IN GENERAL

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. Swelling and bruising, which may necessitate staying home for a few days. Bleeding, sometimes 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 cheeks, gums, teeth, lips, tongue, chin and face. Loss of taste, loss/damage to adjacent teeth and bone, fracture of the 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.

ALTERNATIVES 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.

PHOTOGRAPHS

I hereby specifically authorize Biggio Dental Care 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 publications and I do hereby forever waive any claim to royalties or other monies or other sources of reimbursement that are received from their use.

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 face, arm(s), or leg(s), and disfiguring scars.

ACKNOWLEDGEMENT

I acknowledge that I have read and I understand the above information, 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 have and all of the questions 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 in not currently anticipated.

_____ _____

Signature of Patient or Parent/Guardian if Minor Date

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 THE 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, checks, Visa, MasterCard, Discover, and American Express. For extensive treatment plans, we offer extended payment plans with CareCredit at either little or no interest with prior credit approval.

Be aware that any unpaid balance after 90 days, reaches collection status. If no effort is made to pay it off, the account will be assigned to a collection attorney or agency. If the doctor must take additional steps to collect the account, all costs of collection including court costs and attorney's fees incurred by the doctor will be charged to the patient.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and the extent of dental pathology. I understand that once the treatment plan has begun, complications may arise that dictate additional procedures or treatment. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I authorize Dr. Biggio to make any and all changes and additions as necessary.

MISSED APPOINTMENTS

For you to achieve your optimal dental health, we will depend on you to schedule and keep your dental appointments. Your appointment time is very important to you and our staff. We ask that you notify our office at least 24-48 hours in advance if you cannot keep your scheduled appointment or a $50 fee may be assessed to your account without advance notice of cancellation. All cancellation fees must be paid prior to scheduling another appointment.

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 Biggio Dental Care to release dental information that may be necessary to request claim reimbursement from insurance companies to whom claims may be submitted. I also assign claim payments to be made payable to Biggio Dental Care. I understand that Biggio Dental Care will refund to me any overpayment upon request.

FINANCE CHARGES

Be aware that any unpaid balance after 60 days is charged a yearly finance charge of 18% and that this finance charge is 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 agency or attorney. If the doctor must take additional steps to collect the account, all costs of collection including court costs 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.

_____ _____

Signature of Patient or Parent/Guardian if minor Date

Authorization for Dental Care on a Minor

(This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY)

I authorize dental treatment deemed necessary by the providers at Biggio Dental Care to be rendered on my child/minor, _____, without my physical presence in the dental office. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics.

I have been advised that it is ideal to have a parent/legal guardian present in the office during treatment in case of any complications or medical situations that may arise. With knowledge of this, I authorize Biggio Dental Care to take any emergency care/action or precautions deemed necessary. I still retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

_____	_____	_____
Print your name	Relationship to Patient	Date
_____	_____	_____
Your Signature	Witness	Date

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Signature of Parent or Legal Guardian