OFFICE USE ONLY

Dr. L. _____
N.P.L. _____
Sx. L. _____
Final _____
T.Y. _____

MURRAY L. RABALAIS, JR., P.D., D.D.S.

PERIODONTICS

A Professional Corporation

Name _____ SS# _____ Birth Date _____
Address _____ City _____ Zip _____
Home Phone _____ Office Phone _____ Marital Status _____
Cell Phone _____ Email _____ Fax _____
Occupation _____ Title _____ Occupation (Spouse) _____
Business Name & Address _____
Dentist's Name _____ Referred To This Office By _____
In Case of Emergency Notify _____ Relation _____ Phone _____
Approximate Date of Your Last Medical Appointment _____
Name of Physician _____ Physician's Address (city) _____
Dental Insurance: Yes _____ No _____ Major Medical Insurance: Yes _____ No _____

1. Are you in good GENERAL HEALTH? ..... Yes No
2. Have you ever had excessive bleeding from wounds or extractions? ..... Yes No
3. Has a physician ever told you that you have heart trouble? ..... Yes No
4. Do you get short of breath easily? ..... Yes No
5. Have you gained or lost much weight recently? ..... Yes No
6. Are you taking any medicine at the present time? (Oral contraceptives, Aspirin, Vitamins, etc.) .... Yes No
   What? _____
7. Are you allergic to any medicines? (Such as Penicillin, Codeine, Tylenol, Local anesthetics, etc.) .. Yes No
   What? _____
8. Have you had any surgical operations? (Such as Appendectomy, Hysterectomy, Tonsillectomy, etc.) Yes No
   What? _____
9. Do you have or you had:

Diabetes	Yes	No	Anemia	Yes	No
Rheumatic fever	Yes	No	Asthma	Yes	No
Liver trouble (Hepatitis)	Yes	No	Kidney trouble	Yes	No
High blood pressure	Yes	No	Allergies	Yes	No
Females - Are you pregnant?	Yes	No	Nervousness	Yes	No
Any Diabetes in your family?	Yes	No	Artificial Joints	Yes	No
Mitral Valve Prolapse	Yes	No	Osteoporosis	Yes	No

10. Have you ever taken medication for Osteoporosis? ..... Yes No
11. Have you ever had Chemotherapy ..... Yes No
12. Any other health condition? _____
13. Are you under abnormal stress? (Marital, Business or Social) ..... Yes No
14. Do you have any prosthetic joints (such as knee or hip replacement)? ..... Yes No
15. Have you ever been told to take antibiotics before dental treatment? ..... Yes No

DENTAL HISTORY

1. Are you having dental pain? ..... Yes No
2. Do you have any sores or swollen areas in your mouth? ..... Yes No
3. Does food pack between your teeth? ..... Yes No
4. Do your gums bleed when you brush your teeth? ..... Yes No
5. Have you ever had periodontal treatment? (Scalings, Surgery, etc.) ..... Yes No
6. How often do you visit the dentist? _____
7. What is your chief complaint concerning your mouth or teeth? _____

Signature _____ Date _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ SS# _____ Group # _____ ID#_____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____ Phone: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Address: _____ Phone: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ SS# _____ Group # _____ ID#_____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____ Phone: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Address: _____ Phone: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Therefore, it is the policy of this office to do a credit check on patients that will have a balance on account. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. In understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Murray Rabalais

Telephone: (985)872-2218 Fax: (985)580-4020

E-mail: _____

Address: 236 Progressive BLvd., Houma, LA 70360

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.