Leggio Dental Group

Dr. Ronald S. Leggio Dr. Michael L. Leggio Dr. Michele Leggio-Putnam

Name:_____ Date:_____

Address:_____

City_____State_____ Zip Code_____

Sex:_____ DOB:_____ SSN #:_____ Marital Status:_____

Home Phone:_____ Cell:_____

Employer:_____ Work #:_____

Emergency Contact/Relationship to Patient:_____

Emergency Contact phone #:_____

Email address:_____

Reason for today's visit:_____

How did you find out about our office?_____

Previous Dentist:_____

When was your last cleaning & check-up?_____

Medical Physician:_____

Responsible Party (if patient is under 18):_____

Address of ResponsibleParty_____

Dental Insurance Info:

Dental Ins. Company:_____ Group#:_____

Primary Cardholder:_____ Member ID#:_____

Primary Cardholder's SSN:_____ Primary's D.O.B:_____

HEALTH HISTORY

please check all that apply

____Heart Disease
____Heart Murmur
____Pacemaker
____Angina
____Mitra Valve Prolapse
____Stroke
____High Blood Pressure
____Low Blood Pressure
____Hepatitis/Liver Disease
____Diabetes
____Cancer
____Asthma
____Radiation Therapy
____Venereal Disease
____Herpes
____HIV/ AIDS

____Excessive Bleeding
____Stomach Ulcers
____Allergies/ Hives
____Sinus Problems
____Hysterectomy
____Hormones
____Artificial Joints/replacement
____Oral Contraceptives
____Drug/Alcohol Addiction
____Thyroid Problems
____Kidney Disease
____Rheumatic Fever
____Anemia
____Tuberculosis
____Epilepsy/Convulsion
____Hemophilia

List All Medications you are allergic to:_____

_____

List any medications you are currently taking:_____

_____

Describe any other condition that we should be aware of:_____

_____

PATIENT CONSENT:

I have reviewed the health history form and I hereby authorize that all information given is accurate. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

patient signature (or guardian) date

LEGGIO DENTAL GROUP

4914 Magazine St
New Orleans, LA 70115
(504) 899- 1556

It is our optimal goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your dental needs, we ask you to please observe the following guidelines.

Our Financial Policy:
Unless prior arrangements have been made, payment is due upon completion of treatment. For your convenience, we offer several payment options:
We accept cash, checks, carecredit and Visa/Mastercard/Discover. A fee of $25.00 will be assessed for any returned checks.
Overpayment and credit balances will be refunded at **patient's request** after being processed through our accountant. Credits may be applied to future dental treatment if desired.

Regarding Insurance:
We accept assignment of insurance benefits; however, we do require your co-payment for deductible to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. If your insurance company has not paid your account in full within 60 days, the entire balance will become your responsibility. All accounts over 90 days will be subject to a finance charge of 1.65% per month, which is an annual rate of 19.8%.

Keep in mind insurance does not cover procedures considered cosmetic.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patient's and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. It is the patient's responsibility to verify that Leggio Dental Group is in/out of network provider.

Cancellation Policy:
There are many times when our patients require urgent or emergency treatment and therefore need an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then be allocated to those patients with immediate needs. In this way the office can best serve the needs of ALL patients. Keeping this in mind, our office requires **24 BUSINESS HOURS** notice; otherwise a **$25.00** per appointment hour fee will be assessed.

ALL MINORS MUST BE ACCOMPANIED BY AN ADULT DURING THE ENTIRE LENGTH OF MINOR'S APPOINTMENT.

We at Leggio Dental Group look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

I have read the policies of the Leggio Dental Group and understand my responsibilities as a patient.

Patient Signature: _____ Date: _____

LEGGIO DENTAL GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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: Loc Tran

Telephone: 504-899-1556

E-mail: Leggiodentalgroup@gmail.com

Address: 4914 Magazine St., New Orleans, LA 70115

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.

I, _____, have read and/or received a copy of this office's Notice of Privacy Practices, and have had full opportunity to read and consider the contents of this Consent form. 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 heath 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.