Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child.

Patient Information

Child's Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City_____ State_____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ School _____

Grade _____ Hobbies/Sports _____

Whom may we thank for referring you? _____

Notify in case of emergency_____ Home Phone _____

Business Phone_____ Cell Phone_____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Child _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from child)* _____

City_____ State_____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by_____ Occupation_____

Business Address _____ Business Phone_____

Business Email _____ Insurance Email _____

Insurance Company_____ Phone _____

Contract #_____ Group #_____ Subscriber # _____

Name of other dependents under this plan_____

Additional Insurance

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Child_____ Birthdate _____

Address *(if different from child)*_____ Soc. Sec. # _____

City_____ State_____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone_____

Business Email _____ Insurance Email _____

Insurance Company_____ Phone _____

Contract #_____ Group #_____ Subscriber # _____

Name of other dependents under this plan_____

Please complete both sides.

Dental History

What would you like us to do for your child today? _____

_____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? ❑ Y ❑ N

Has your child ever experienced a mouth or chin injury? ❑ Y ❑ N

Does your child have speech problems?

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Child's habits affecting the mouth or teeth: ❑ Thumb sucking ❑ Nail biting ❑ Other _____

Other information about your child's dental health or previous treatment _____

_____

Medical History

Child's Physician _____ Phone _____

Physician's Email _____

Date of last visit _____ Has your child had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Is your child currently under physician care? ❑ Y ❑ N If yes, describe _____

Has your child ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Has your child ever taken Fen-Phen/Redux? ❑ Y ❑ N

Check (✓) yes or no whether your child has had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anemia
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chicken Pox
❑ Y ❑ N Convulsions/Epilepsy
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Headaches
❑ Y ❑ N Hearing Impairment
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Immunizations current
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Sinus problems
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Other
Describe _____

List medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

HIPAA RECEIPT OF NOTICE/AUTHORIZATION FORM FOR THE OFFICE OF DR. TODD BAKER

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

As required by the Privacy Regulation, I am aware that this practice has included a provision that it reserves the right to change the terms of it's notice and to make the new notice provisions effective for all protected health information that it may maintain.

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

YES	NO	
____	____	My name, address, social security number, group number, birth date and employer information to my insurance company/companies for the purpose of reimbursement for treatment rendered.
____	____	May our office/staff call your home and leave a message on your recorder,voice mail or with a family member about an appointment?
____	____	May our office contact you at work to change or confirm an appointment?
____	____	May our office/staff call your place of employment and leave a message about your appointment with a co-worker/voice mail?
____	____	May our office/staff, at your request, call your pharmacy and give your name, birth date and address for prescription/prescriptions?
____	____	May our office/staff give information about your x-rays, treatment, insurance information including birth date and ID # to a specialist such as an Endodontist, Periodontist, Orthodontist, Pedodontist or Oral Surgeon?
____	____	May we contact you by Email ? _____
____	____	May we contact you by Text Message ? Cell Phone #:_____
		May a family member get information about:
____	____	An appointment time/details about an appointment?
____	____	Amount of a bill or an account balance.

If you answered yes to either of the last 2 questions, please list the names of the family members who are allowed to request said information:

Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

If you cannot pick up a prescription from us, can the person/persons listed above, pick up prescriptions for you?_____

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES", and that _____(Staff Member) has answered any questions that I may have had concerning said Privacy Practices to my satisfaction.

DATE:_____PATIENT:(PleasePrint)_____

RELATIONSHIP TO PATIENT:_____SIGNATURE:_____

By signing above, you also agree that you understand that:

- This authorization shall remain in effect from the above date until written withdrawl/or request for change is received by this office.
- That you may inspect or copy the protected health information to be used/disclosed.
- Information used or disclosed pursuant to this authorization may be subject to redislosure by the recipient and no longer protected by this HIPPA AUTHORIZATION.
- You may refuse to sign this authorization and that we will not condition treatment based upon that refusal. (Patient's with insurance coverage, who refuse to sign this authorization should be aware that they will be responsible for full payment of services rendered, on the day of service.)

DEAR PATIENT;

IT HAS RECENTLY COME TO OUR ATTENTION THAT MANY OF OUR PATIENTS DO NOT KNOW OF CERTAIN OFFICE POLICIES THAT ARE IN PLACE. PLEASE READ AND SIGN THIS "EXPLAINATION OF OFFICE POLICIES FOR DR. TODD M. BAKER".

THANK YOU.

- ALL DEDUCTIBLES AND **ESTIMATED CO-PAYS** ARE DUE ON THE DATE OF SERVICE. WE MAKE EVERY EFFORT TO GATHER ACCURATE INFORMATION CONCERNING YOUR DEDUCTIBLES AND CO-PAYS FROM YOUR INSURANCE COMPANY, HOWEVER, THERE ARE TIMES WHEN YOU WILL BE LEFT WITH A CREDIT OR A BALANCE WE DID NOT ANTICIPATE. BY SIGNING THIS NOTIFICATION, YOU ACKNOWLEDGE THAT ANY BALANCE REMAINING ON YOUR ACCOUNT AFTER INSURANCE HAS PAID WILL SOLELY BE YOUR RESPONSIBILITY.

- IF YOU NEED TO CHANGE OR CANCEL AN APPOINTMENT, WE ASK THAT YOU GIVE THE OFFICE AT LEAST 48 HOURS NOTICE. THIS ALLOWS US TO SCHEDULE OTHER PATIENTS WHO NEED TO BE SEEN. IF YOU DO NOT GIVE US AT LEAST 24 HOURS NOTICE, YOU COULD BE CHARGED.

- OUR OFFICE GLADLY OFFERS SATURDAY AND EVENING HOURS. IF YOU SCHEDULE AN APPOINTMENT AT EITHER OF THESE TIMES AND DO NOT GIVE US SUFFICIENT NOTICE OF CHANGE (24 OR MORE HOURS) OR DO NOT SHOW UP FOR AN APPOINTMENT, WE WILL NOT BE ABLE TO SCHEDULE ANY FUTURE APPOINTMENTS FOR THOSE TIMES. YOU WILL ALSO BE CHARGED $50.00 PER APPOINTMENT TIME.(THIS MEANS IF THERE WERE 2 APPOINTMENT TIMES FOR DIFFERENT FAMILY MEMBERS, YOU WILL BE CHARGED **$50.00** FOR EACH FAMILY MEMBER WHO MISSES AN APPOINTMENT.) THESE ARE OUR MOST REQUESTED APPOINTMENTS AND IT IS NOT FAIR TO OTHER PATIENTS , DR. BAKER OR STAFF IF THERE ARE UNFILLED APPOINTMENTS BECAUSE WE WERE NOT NOTIFIED IN SUFFICIENT TIME TO FILL THEM.

- WE MAKE EVERY EFFORT TO REMIND YOU OF AN APPOINTMENT YOU MADE 6 MONTHS IN ADVANCE. ONE MONTH PRIOR TO YOUR APPOINMTMENT YOU WILL RECEIVE AN E-MAIL CONFIRMATION, 2 HRS. PRIOR TO YOUR APPOINTMENT YOU WILL RECEIVE A TEXT MESSAGE AND WE WILL CALL 1-2 DAYS PRIOR TO CONFIRM YOUR APPOINTMENT. **PLEASE BE SURE TO CALL US WITH ANY CHANGES AS TO YOUR ADDRESS / PHONE NUMBERS / EMAILS AS SOON AS POSSIBLE SO THAT WE CAN CONTACT YOU.**

THESE POLICIES ARE IN PLACE TO BETTER SERVE ALL OF OUR PATIENTS. WE THANK YOU FOR YOUR UNDERSTANDING.

DR. BAKER AND STAFF

DATE:_____ SIGNATURE:_____