WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental heathcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS #/SIN _____ E-Mail _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS #/SIN _____

Address _____ E-Mail _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS #/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS #/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

5 Authorization and Release

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 other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash
_____ Personal Check
_____ Credit Card ____ Visa ____ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty in chewing?	❒	❒
13. Have you had any head, neck, or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plane or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in the dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

B Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	❒	❒
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	❒	❒
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	❒	❒
8. Have you ever taken Fen-Phen/Redux?	❒	❒
9. Have you had any abnormal bleeding?	❒	❒
10. Do you bruise easily?	❒	❒
11. Have you ever required a blood transfusion	❒	❒
12. Have you had a recent weight loss?	❒	❒
13. Do you have a persistant cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❒	❒
14. Do you use tobacco?	❒	❒
15. Do you use alcohol or cocaine or other drugs?	❒	❒
16. Are you wearing contact lenses?	❒	❒
17. Do you have any disease, condition or problem not listed above that you think I should know about?	❒	❒
Women Only:		
1. Are you pregnant or think you may be pregnant?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

(OVER)

C Medical History Continued...

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin or other antibiotics?	☐	☐
3. Sulfa drugs?	☐	☐
4. Barbiturates, sedatives or sleeping pills?	☐	☐
5. Aspirin?	☐	☐
6. Iodine?	☐	☐
7. Other? _____	☐	☐
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	☐	☐
2. Scarlet fever?	☐	☐
3. Heart defect or heart murmur?	☐	☐
4. Heart trouble, heart attack, or angina?	☐	☐
a. Do you have pain in your chest upon exertion?	☐	☐
b. Are you ever short of breath after mild exercise?	☐	☐
c. Do your ankles swell?	☐	☐
d. Do you get short of breath when you lie down?	☐	☐
e. Do you require extra pillows when you sleep?	☐	☐
5. Pacemaker?	☐	☐
6. Heart surgery?	☐	☐
7. High blood pressure?	☐	☐
8. Low blood pressure?	☐	☐
9. Hepatitis, jaundice or liver disease?	☐	☐
10. Stroke?	☐	☐
11. Sinus trouble?	☐	☐
12. Lung or breathing problems?	☐	☐
13. Asthma or hay fever?	☐	☐
14. Hives or skin rash?	☐	☐
15. Fainting spells or seizures?	☐	☐
16. Diabetes?	☐	☐
17. AIDS or HIV infection?	☐	☐
18. Thyroid problems?	☐	☐
19. Allergies?	☐	☐
20. Arthritis or rheumatism?	☐	☐
21. Joint replacement or implant?	☐	☐
22. Stomach ulcer?	☐	☐
23. Kidney trouble?	☐	☐
24. Tuberculosis?	☐	☐
25. Persistent cough?	☐	☐
26. Cough that produces blood?	☐	☐
27. Cancer?	☐	☐
28. Sexually transmitted disease?	☐	☐
29. Epilepsy?	☐	☐
30. Anemia?	☐	☐
31. Leukemia?	☐	☐
32. Glaucoma?	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

SUMMARY OF MEDICAL HISTORY

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS: PATIENT	DENTIST	HYGIENIST

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:_____