BAKER SISTERS
FAMILY DENTAL CARE

## Patient Information

Date_____

Patient Name _____ Preferred Name_____ Age_____

Gender _____ Birthdate ____/____/____ SINGLE MARRIED DIVORCED WIDOWED

Mailing Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____ SS#_____

Email Address _____@ _____How did you hear about our office?_____

Employer Name_____ Work Phone_____

Emergency Contact Name_____ Relationship_____ Phone_____

## Responsible Party

Name of person responsible for this account (if **OTHER THAN YOURSELF**) _____

Relationship to patient _____ SS #_____ Birthdate _____/____/____

Home Phone_____ Cell Phone_____ Is this person currently a patient? YES NO

Employer Name_____ Work Phone_____

## Primary Dental Insurance Information

Name of Primary Policyholder _____ Relationship to patient _____

SS# or Policyholder ID#_____ Group #_____ Birthdate _____/_____/_____

Employer Name_____

Name of Dental Insurance Company_____ Phone #_____

## Secondary Dental Insurance Information

Name of Primary Policyholder _____ Relationship to patient _____

SS# or Policyholder ID#_____ Group #_____ Birthdate _____/_____/_____

Employer Name_____

Name of Dental Insurance Company_____ Phone #_____

## Dental History

Reason for today's visit?_____ Are you on well water? **YES or NO**

Former Dentist _____Date of last dental visit? ____/____/____

How often do you brush?_____ How often do you floss?_____

Are you happy with your smile? **YES or NO** If no, please explain _____

Do you have sensitivity in your mouth? **YES or NO** If yes, please explain _____

Have you had any of the following? ☐ Orthodontic Treatment ☐ Denture/Partial ☐Gum treatment ☐Night Guard

## Medical History

Physician's Name _____ Phone Number _____

Are you currently under physician's care? **YES or NO** If yes, please explain _____

Have you had any hospitalizations, operations or major surgeries? **YES or NO** If yes, please explain _____

_____

Do you require antibiotic prophylaxis for dental treatment due to any medical condition/surgery? **YES or NO**

Are you currently taking or have you ever taken Bisphosphonates **YES or NO**

**Women:** Are you pregnant? **YES or NO** If yes, due date ___/___/___ If no, are you taking oral contraceptive? **Yes or NO**

**Medications currently taking:** List any medications you are taking and correlating diagnosis

_____

_____

**Medications for emergency?** Have you ever carried/do you currently carry any medication in case of an emergency?

☐ Nitroglycerin ☐ Glucose ☐ Insulin ☐Inhaler ☐Epi Pen

**Allergies:** Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Sulfa

Any other allergies? _____

## Habits

☐ Use tobacco Type? _____ How long? _____How much per day?_____

☐ Use alcohol? How much per WEEK? _____ ☐ Use Drugs _____

## Do you have or have you had any of the following?

☐ AIDS/HIV
☐ Artificial Heart Valves
☐ Cancer
☐ Congenital Heart Disease
☐ Emphysema
☐ Diabetes
☐ Glaucoma
☐ Heart Pacemaker
☐ Behavioral/Social Disorders
☐ Kidney Disease/Dialysis
☐ Lung Disease
☐ Psychological Disorders
☐ Renal Dialysis
☐ Shingles
☐ Stroke
☐ Swollen Neck/Glands
☐ Tuberculosis

☐ Anemia
☐ Artificial Joints
☐ Back Problems
☐ Chemotherapy/Radiation
☐ Cortisone Treatments
☐ Epilepsy or Seizures
☐ Heart Attack, Surgery, Disease
☐ Hepatitis Type _____
☐ High Blood Pressure
☐ Liver Disease
☐ Measles/Measles Vaccine
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Stomach Disease
☐ Thyroid/Parathyroid Disease

☐ Arthritis, Rheumatism
☐ Asthma
☐ Abnormal Bleeding
☐ Cold Sores/Fever Blisters
☐ Dental Anxiety
☐ Fainting or Dizziness
☐ Heart Murmur/MVP
☐ Headaches
☐ High Cholesterol
☐Infective Endocarditis
☐ Low Blood Pressure
☐ Respiratory Disease
☐ Scarlet Fever
☐ Sinus Trouble
☐ Intestinal Disease
☐ Tonsillitis
☐ Venereal Disease

Any conditions not listed above? _____ _____

**Signature of patient or parent:** _____

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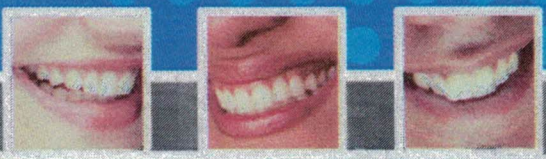

# Financial Agreement

Thank you for choosing our office. We are committed to providing you with the best possible care. If you have any questions regarding fees for treatment, please feel free to discuss them with us. We will make every effort to avoid misunderstandings and preserve our relationship.

Payment for services is due at the time treatment is rendered. If you have dental insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. We will be happy to process your insurance claims for reimbursement as well as accept insurance assignment from insurances we are participating providers with. Our office is provided with "general benefit" information from your insurance, which is not specific or a guarantee of benefits or payments. If for any reason your insurance denies a claim you will be responsible for the balance.

Your deductible if any and "estimated co-payment" are collected at the time of service. We cannot guarantee exact amounts to be paid by your insurance carrier. If there is any remaining balance after your insurance has processed your claim, the balance is your responsibility.

Missed and broken appointments waste valuable manpower and raise fees for everyone. In an effort to reduce this expensive waste there will be a charge of $50 for broken or missed appointments. A broken appointment is classified as the failure to appear for an appointment, cancellations not made 48 hours in advance or lateness that results in an inability to complete scheduled treatment.

Returned checks due to insufficient funds or closed accounts will have a $35 charge.

If your account must be placed in the hands of a third party for collections, your account will be charged 1/3 of the total balance for collection fees.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

# Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

SMILE SISTERS, LLC

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

## Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

## For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____ Date: ___/___/___