WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible.
If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name _____(If child, parent/guardian name) _____
Last name First name Initial

Birthdate _____ Sex _____ Age _____ Social Security Number_____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail _____ Driver's License Number _____

How did you hear about our practice? _____
Employer _____ Occupation _____ How long there? _____ May we call? _____
Employer Address _____ City _____ State _____ Zip _____

Spouse's Name (Or other parent/guardian) _____ Social Security Number _____
Spouse's Employer _____ Occupation _____ How long there? _____ May we call? _____
Spouse's Employer Address _____ City _____ State _____ Zip _____

If patient is a student: Name of school / college: _____ City & State _____ Full time or part time? _____

Primary Insurance:

Name of Insured _____
Birthdate _____ Relationship to Patient _____
Address (if different from patient) _____
Dental Insurance Co. _____ Phone _____
Social Security # _____ Subscriber ID# _____
Group, Contract or Local or union # _____

Additional Insurance:

Name of insured _____
Birthdate _____ Relationship to Patient _____
Address (if different from patient) _____
Dental Insurance Co. _____ Phone _____
Social Security # _____ Subscriber ID# _____
Group, Contract or Local or union # _____

Copayments:

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:
CIRCLE ONE: Visa Mastercard Discover Amex
Account# _____ Expiration date _____ Name on the card _____
☐ Credit Card ☐ Debit Card ☐ ATM ☐ Voided check attached

In Case of Emergency:

Name and City of primary care physician _____
Someone we may contact, not living with you: _____ Phone #'s (home, work, cell) _____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costsif this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature_____ Date_____

Dental History

Patient's Name _____ Age _____ Date _____
Reason for seeking care today: _____ Exam _____ Cleaning _____ Specific Problem _____
(please describe)

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums Bleed
- ☐ Gums tender
- ☐ Growths, sores
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe – Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily
- ☐ Hold things between teeth (Pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?
_____

Please rate 1 – 10 how anxious you are about dental treatment (1 = totally relaxed) _____
Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____
Why did you leave your previous dentist?_____ _____
Did your parents have difficulties with their teeth or dental treatments? _____

Medical History

Physician's Name: _____
City _____ Phone _____
Have you been hospitalized for any reason? Please Describe:
_____
_____
_____
Are you taking any medications or drugs (including nutritional supplements)? Please list:(continue on back of form if needed)
_____
_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other?
_____
_____
Do you smoke? How much / day? _____
Pregnant? Due date? _____ Are you nursing? _____
Are you seeing a physician now or planning to see one for any reason? Please explain:
_____
_____

Please check all that apply:

- ☐ Previous injury to head or neck
- ☐ Heart problem
- ☐ Heart attack
- ☐ Angina, chest pain
- ☐ Heart murmur
- ☐ Scarlet, Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Irregular heartbeat
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Artificial joint
- ☐ Diabetes
- ☐ HIV or AIDS
- ☐ Kidney problem
- ☐ Liver problem, jaundice
- ☐ Cirrhosis, Hepatitis
- ☐ Cancer
- ☐ Radiation, Chemotherapy
- ☐ Respiratory problem
- ☐ Bloody, persistent cough
- ☐ Asthma, Emphysema
- ☐ Anemia
- ☐ Sickle cell
- ☐ Digestive problems, ulcer
- ☐ Thyroid disease
- ☐ Glaucoma
- ☐ Bleed or bruise easily
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Back problem
- ☐ Hives, rash, Herpes
- ☐ Dry eyes
- ☐ Shortness of breath
- ☐ Snoring, sleep apnea
- ☐ Easily winded
- ☐ No energy
- ☐ Fainting or dizzy
- ☐ Unexplained weight loss
- ☐ Chewing tobacco
- ☐ Drug or alcohol addiction
- ☐ Two or more social drinks / day
- ☐ Anxiety or nervous disorder
- ☐ Insomnia
- ☐ Contact lenses

Any other illnesses not checked above _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ Yes ☐ No
Please rate the following indicators of your daily stress level: 1-10: (1 = low, 10 = high)
_____ Overworked, too busy, pressured _____ Feel frustrated _____ Get upset, or "snap" easily _____ Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or both. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date _____

Dentist Signature_____ Date _____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below Patient Name _____

WORK TO BE DONE **Initial _____**

I understand that I am having the following work done: Fillings ____ Bridges ____ Crowns ____ Extractions _____ Impacted teeth removed _____ General Anesthesia ____ Root Canals _____ Other_____

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (sever allergic reaction).

CHANGES IN TREATMENT PLAN **Initial _____**

I understand that during treatment it may be necessary to change or add procedures because of condition found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changed and additions as necessary.

REMOVAL OF TEETH **Initial _____**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery etc) and I authorize the dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, and some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days of months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

CROWN, BRIDGES AND CAPS **Initial _____**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

DENTURES, COMPLETE OR PARTIAL **Initial _____**

I realize that full or partial dentures are artificial, constructed of acrylic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, include looseness, soreness and possible breakage. I realize the final opportunity to make changed in my new dentures (including shape, fit , size, placement, and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of the procedure is not included in the initial denture fee.

ENDODONTIC TREATMENT (ROOT CANAL) **Initial _____**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

PERIODONTAL LOSS (TISSUE & BONE) **Initial _____**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask question. My questions have been answered to my satisfaction. I am signing below that I have read and understood this form.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____

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We love to care for your smile...

CLASSIC SMILES
COMPLETE FAMILY & COSMETIC DENTISTRY

HIPAA Acknowledgement Form

Protecting patient information is a big part of our everyday care.
Our notice of Privacy provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care options as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name

(print) _____

(signature) _____

Date: _____

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CLASSIC SMILES

COMPLETE FAMILY & COSMETIC DENTISTRY

Susanne Inez Baaqee, D.M.D.

Our Financial Policy

Patient Name: _____ Parent/Guardian Name_____

Thank you for choosing us as your health care provider. We strive to provide you with the best quality, gentle dental care possible. If we can help you in any way please don't hesitate to ask us.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/AMERICAN EXPRESS

Regarding Insurance:
Your insurance is a contract between you and the insurance company. We are not a party to that contract. Dental insurance is not meant to be a pay-all option but meant to be an aid. So please, be aware that some and perhaps all of the services provided under your particular policy may be considered **"Non-Covered Benefits"** above their **"Usual and Customary Fee"** or based on a set **"Fee Schedule".** Your benefits are dependant on how much your employer paid for your particular plan. If you have any questions regarding the detail of your plan, we ask that you contact your job. Regardless of what insurance pays, the final balance on your account is considered your responsibility. We are happy to assist you in receiving your maximum allowable benefits and require all pertinent insurance information to be given to us so that eligibility and general benefits can be verified. Once confirmed, our office will be able to accept assignment of benefits and bill your insurance company directly. Please understand that we cannot predict exactly what your insurance company will pay on a particular procedure or service and only an estimate can be determined of the charges based on the information your insurance company is willing to provide. An annual deductible and any required co-payment on a particular service will have to be collected at the time of service, and can only be based on the general information released by your insurance company. We will bill your insurance company as services are rendered. Payment is expected within 30 days of that billing. Any services not paid after the 45 day wait period will become immediately due in full. Accounts over 60 days past due will be subject to a monthly billing service charge. Accounts over 90 days will be sent to collections.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Dental insurance usually covers Basic dental procedures. Complex comprehensive procedures and Cosmetics are often times **"Non –Covered Services".**

Change or Termination of Insurance:
If your insurance coverage changes or is terminated, please notify our office so we can update our information.

Returned Checks, Service Charge on Unpaid Balance:
We will be happy to accept your payment by check. For all returned checks there will be a maximum **service charge** of $50. We also reserve the right to charge your account a monthly billing service charge on unpaid balances after 60 days.

Cancellation of Appointment:
If for any reason you are unable to keep your appointment, kindly give us 48 hours notice. Without 48 hours notice your account will be **charged a fee** of $50-$75 depending on how much time was blocked for your treatment after the **second** cancelled appointment.

I have had the opportunity to read this form, ask questions, understand and agree to the terms of the Financial Policy.

_____ _____
Signature of Patient or Legal Guardian Date

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