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 Type _____
☐ Congenital Heart Disease
☐ Emphysema
☐ Diabetes Type _____
☐ 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: _____

BAKER SISTERS
FAMILY DENTAL CARE

8025 Ritchie Highway Suite 205 Pasadena, MD 21122 410-768-7740

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, 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 a "general benefit" 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-$100 for broken or missed appointments. A broken appointment is classified as the failure to appear for an appointment, cancellations not made 48 business 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:_____ Date:_____

Relationship to patient: SELF ☐ PARENT OR GUARDIAN ☐

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: ___/___/___

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

All dental related information to include, but not limited to, treatment, appointments and financials unless specified here:

I hereby authorize Baker Sisters Family Dental Care

Name of individual(s) and/or organization providing information

to release the above-described information to _____.

Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

Baker Sisters Family Dental Care.

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on in writing. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

Expiration date or event

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: / /

Name: _____

Please Print

Relationship to Patient: _____

For Office Use Only

Received by: _____ Date: / /