Patient Information

Today's Date _____

Patient Name: First_____ MI_____
Last_____Nickname_____

Address: Street_____ City_____ State_____
Zip_____

Phone: Home_____ Work_____ Cell _____ E-mail address_____

How did you learn about our office? [ ] One of our valued patients (name of patient)_____

[ ] a friend [ ] Insurance List [ ] Walking by [ ] Advertisement _____ [ ] Web site [ ] Other_____

What is your preferred method of contact? [ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] E-Mail [ ] Snail Mail

Social Security Number_____ **Date of Birth**_____ **Drivers License # State**_____

Sex [ ] Male [ ] Female **Marital Status** [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other _____

Person to Contact in case of emergency_____**Relationship**_____ **Phone:**_____
Cell:_____

Patient Employed By_____**Occupation**_____**May we call work phone? Y__ N__**

Address: Street_____ City_____ State _____
Zip_____

Full-time Student [ ] Yes [ ] No **Name & Location of School**_____**Is the patient a Minor?** [ ]Yes [ ] No

If patient is a Minor, primary residency: [ ] Both Parents [ ] Mom [ ] Dad [ ] Step Parent [ ] Shared Custody [ ] Guardian

Pharmacy Name _____ Location _____

Phone Number _____ _____

Responsible Party: First_____MI _____ Last _____ Date of Birth _____

Relation to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Other _____ **Phone**: Home_____ Cell_____

(if different) **Address:** Street_____ City_____ State_____
Zip_____

(if different) **Phone:** Home_____ Cell_____ **Drivers Lic # State**_____ **Employer** _____

Occupation _____**Address:** Street_____ City_____ State_____ Zip_____ **Phone**_____

Do You Have Dental Insurance? Yes No

If Yes: please show your insurance card or at least give enough information for us to call your insurance company and verify (as best your insurance company will tell us) what your insurance company can do for you:

Authorizations: I confirm that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and give consent to diagnosis and treatment services. **(initial)**_____

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.

YES / NO (Circle One) **(initial)**_____

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I authorize the outlined disclosures. I have been given the opportunity to ask any questions I may have regarding this Notice. **(initial)** _____

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I accept recommended materials and I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. **(initial)** _____

Signature _____**Date** ____ ____

Signature (responsible party if not patient, or patient a minor) _____**Date** _____

Patient Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. Are you under medical treatment now?	[]	[]
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ..	[]	[]
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	[]	[]
If yes, what medication(s) are you taking?		
4. Have you ever taken Fen-Phen/Redux?	[]	[]
5. Do you use tobacco?	[]	[]
6. Do you use controlled substances?	[]	[]
7. Are you wearing contact lenses?	[]	[]
8. Do you have or have you had any of the following?		

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	[]	[]
Penicillin or any other Antibiotics	[]	[]
Sulfa Drugs	[]	[]
Barbiturates	[]	[]
Sedatives	[]	[]
Iodine	[]	[]
Aspirin	[]	[]
Any Metals (e.g. nickel, mercury, etc.)	[]	[]
Latex Rubber	[]	[]
Other (please list) _____	[]	[]

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	[]	[]
11. Women Only:		
a) Are you pregnant or think you may be pregnant? ..	[]	[]
b) Are you nursing?	[]	[]
c) Are you taking oral contraceptives?	[]	[]

	Yes	No		Yes	No		Yes	No
High Blood Pressure	[]	[]	Heart Disease	[]	[]	Chest Pains	[]	[]
Heart Attack	[]	[]	Cardiac Pacemaker	[]	[]	Easily Winded	[]	[]
Rheumatic Fever	[]	[]	Heart Murmur	[]	[]	Stroke	[]	[]
Swollen Ankles	[]	[]	Angina	[]	[]	Hay Fever / Allergies	[]	[]
Fainting / Seizures	[]	[]	Frequently Tired	[]	[]	Tuberculosis	[]	[]
Asthma	[]	[]	Anemia	[]	[]	Radiation Therapy	[]	[]
Low Blood Pressure	[]	[]	Emphysema	[]	[]	Glaucoma	[]	[]
Epilepsy / Convulsions	[]	[]	Cancer	[]	[]	Recent Weight Loss	[]	[]
Leukemia	[]	[]	Arthritis	[]	[]	Liver Disease	[]	[]
Diabetes	[]	[]	Joint Replacement or Implant ..	[]	[]	Heart Trouble	[]	[]
Kidney Diseases	[]	[]	Hepatitis / Jaundice	[]	[]	Respiratory Problems	[]	[]
AIDS or HIV Infection	[]	[]	Sexually Transmitted Disease ..	[]	[]	Mitral Valve Prolapse	[]	[]
Thyroid Problem	[]	[]	Stomach Troubles / Ulcers	[]	[]	Other _____	[]	[]

Patient Dental History

*Name of Previous Dentist and Location*_____ *Date of Last Exam* _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	[]	[]
2. Are your teeth sensitive to hot or cold liquids/foods? ..	[]	[]
3. Are your teeth sensitive to sweet or sour liquids/foods? ..	[]	[]
4. Do you feel pain to any of your teeth?	[]	[]
5. Do you have any sores or lumps in or near your mouth? ..	[]	[]
6. Have you had any head, neck or jaw injuries?	[]	[]
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	[]	[]
Pain (joint, ear, side of face)	[]	[]
Difficulty in opening or closing	[]	[]
Difficulty in chewing	[]	[]

	Yes	No
8. Do you have frequent headaches?	[]	[]
9. Do you clench or grind your teeth?	[]	[]
10. Do you bite your lips or cheeks frequently?	[]	[]
11. Have you ever had any difficult extractions in the past?	[]	[]
12. Have you ever had any prolonged bleeding following extractions?	[]	[]
13. Have you had any orthodontic treatment?	[]	[]
14. Do you wear dentures or partials?	[]	[]
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	[]	[]
16. Do you like your smile?	[]	[]

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 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.

Signature of patient (or parent/guardian if minor) _____

Doctor's Comments _____

Signature _____ *Date* _____

RICHARD H. BALDWIN D.M.D.

PATIENT CONSENT FORM FOR HIPPA PRIVACY

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

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved directly and indirectly in that treatment;

Obtain payment from third-party payers;

Conduct normal healthcare operations such as quality assesments and physician certifications;

In each case the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

When providing information to me, the patient, this office may transmit information to me by the following means:

Telephone message on an answering machine

Messages to family members, such as spouse or parent if minor

Faxed information at my request

I have been informed that your notice of Privacy Practices, posted in your reception room, contains a complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address below to obtain a current copy of the notice.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out, treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke the consent in writing at any time, except to the extent that you have taken action relying on this consent.

Name:_____