Patient Information

Patient Name: _____ _____ ____ _____
Last First Mid Prefered Name

Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Child ❑Widowed ❑Divorced
Date of Birth: _____ SS#: _____
Employer: _____ Occupation: _____
How did you hear about us? _____
(If referred by another person, may we thank them on your behalf?_____)
Student Status if over 19 (for ins): ❑Non-Student ❑Full-Time Student ❑Part-Time Student
College Name:_____

Contact Information

Home Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Wireless #: _____ Okay to Text for Appointment Reminders: ❑Yes ❑No
Work #:_____ Okay to contact at this number? ❑Yes ❑No
Email: ***
Preferred method of contact: ❑Cell # ❑ Home # ❑Work # ❑E-mail ❑Text

Emergency Information

Drivers License #: _____
**pease provide a copy of your license to the receptionist. Thank you!
Emergency Contact: _____ Relationship to Patient: _____
Emergency Contact Phone #: _____

Responsible Party (Financial)

❑Please check here if same as above
Name: _____ Relationship to Patient: _____
Address: _____ City, State, Zip: _____
Wireless #: _____ Home #_____ Email: _____
Birthdate: _____ Soc Sec #: _____ Drivers License #_____

Primary Dental Insurance

Relationship to Subscriber: ❑Self ❑Spouse ❑Child
Subscriber Name: _____ Subscriber DOB: _____
Subscriber SS#:_____ Subs ID: _____
Subscriber Group #: _____ Group Name: _____
Subscriber's Employer: _____
Insurance Company: _____ Insurance Phone Number: _____
Date you started this plan: _____
*please present insurance cards and ID to receptionist

Secondary Dental Insurance

Relationship to Subscriber: ❑Self ❑Spouse ❑Child
Subscriber Name: _____ Subscriber DOB: _____
Subscriber SS#:_____ Subs ID: _____
Subscriber Group #: _____ Group Name: _____
Subscriber's Employer: _____
Insurance Company: _____ Insurance Phone Number: _____
Date you started this plan: _____
*please present insurance cards and ID to receptionist

I guarantee that the information on this form is true and accurate to the best of my knowledge.

Signature of Patient/Guardian: _____ Date: _____

Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Tylenol
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa
☐	☐	Food/Food Dye	☐	☐	Other

If yes, please explain allergic reaction:

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease	☐	☐	Blood Disorder
☐	☐	Bleeding Problems	☐	☐	Liver Disease	☐	☐	Alzheimer's
☐	☐	Cancer	☐	☐	Lung Disease	☐	☐	Dementia
☐	☐	Diabetes	☐	☐	Psychiatric Treatment	☐	☐	Heart Valve Replacement
☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐	Osteoporosis
☐	☐	Heart Condition	☐	☐	Stroke	☐	☐	Thyroid Disease
☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐	Parathyroid Disease
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever	☐	☐	Swelling of Limbs
☐	☐	Heart Attack/Failure	☐	☐	Auto-immune Disorder	☐	☐	Glaucoma
☐	☐	Pacemaker	☐	☐	Arthritis	☐	☐	History of Drug Addiction
☐	☐	Hepatitis	☐	☐	Recent Weight Loss/Gain	☐	☐	Hypoglycemia
☐	☐	Chron's Disease	☐	☐	Low Blood Pressure	☐	☐	High Cholesterol
☐	☐	Take Blood Thinners	☐	☐	History of Smoking	☐	☐	Other

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

Have you been recommended to take Pre-Med Antibiotics before a dental appt?
(such as Joint Replacement, Heart Valve Replacement, Previous history of Endocarditis, etc): [Y] ___ [N] ___

Y	N	Women Only:
☐	☐	Are you Pregnant or trying to get Pregnant?
		Due Date if applicable:
☐	☐	Breastfeeding?
☐	☐	Taking Birth Control?

Signature: _____ Date: 02/26/2018

PURE DENTAL
Dawn C. Baker, DDS

DENTAL HISTORY

Patient Name: _____ Date: _____

*Reason for this visit: _____
*Last Dental Cleaning (approx): _____ Previous Dentist: _____

*Have you had a bad dental experience in the past? _____

*Do you feel anxious at dental appointments?_____

*Do you take medication for osteoporosis or blood thinners? _____

*Have you ever had gum treatments/periodontal scaling/deep cleaning?_____

*Have you had any adverse reactions to anesthetic/numbing agents? _____

*Do you have history of any of the following:

Y	N		Y	N	
❑	❑	Bleeding Gums			
❑	❑	Clenching or Grinding	❑	❑	Suck thumb, finger or lip
❑	❑	Injuries to Face/Teeth	❑	❑	Bite Lips or Cheeks Frequently
❑	❑	Loose Teeth	❑	❑	Food or Floss Catches between Teeth
❑	❑	Difficult to Open Mouth	❑	❑	Difficult Extractions in Past
❑	❑	Jaw Locking Open or Closed	❑	❑	Prolonged Bleeding
❑	❑	Jaw Clicks or Pops	❑	❑	Wear/worn Dentures or Partials
❑	❑	Missing or Extra Teeth	❑	❑	Get Sores on Lips (Cold Sores)
❑	❑	Mouth Breathing	❑	❑	Get Sores in Your Mouth
❑	❑	Nail Biting	❑	❑	Difficulty Chewing/Swallowing
❑	❑	Periodontal Surgery	❑	❑	Teeth Sensitivity to Cold/Hot
❑	❑	Speech problems	❑	❑	Exposed to Medications that Affect Teeth
❑	❑	Snoring	❑	❑	Failed Implants
❑	❑	Sleep Apnea			
❑	❑	Tooth Pain			
❑	❑	Jaw Joint Pain			

*Are you interested in sedation options for dental treatment? _____

*Are you happy with your smile? _____If not, what would you change? _____
_____

*Are you interested in whitening options? _____

*What are your expectations or overall goal for your dental health? _____
_____

I certify that to the best of my ability, this form has been completed to my satisfaction. I will not hold the dentist or any staff responsible for any errors that I have made while completing this form.

Signature _____ Date: _____

Dentist Reviewed: _____ Date: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF PAYMENTS

(only for patients who have dental insurance)

INSURANCE AUTHORIZATION

Dental insurance varies greatly from policy to policy. It is a contract between you and your insurance company. I authorize Pure Dental to file my insurance claims as a courtesy. Pure Dental will do its best to help you understand your policy benefits. Please be aware sometimes services provided may be non-covered services or not considered usual, customary, and reasonable under the terms of your dental and/or medical policy.

We will provide an estimate based off of the information obtained from your insurance company. Any estimates we provide are subject to change. The balance is your responsibility, whether your insurance company pays or not. ***Estimates are due at the time of service.*** If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account.

USUAL & CUSTOMARY FEES

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 fees.

ASSIGNMENT OF INSURANCE PAYMENTS OTHERWISE DUE TO INSURED

I certify that I and/or my dependent(s), have dental insurance coverage and assign directly to Dawn C. Baker, DDS, LLC all insurance benefits, if any, otherwise payable to me for services rendered. If payments are made directly to me by my insurance, I will remain responsible for the balance due. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dawn C. Baker, DDS, LLC, aka Pure Dental, may use my health care information and may disclose such information in accordance with applicable laws, to the below-named Insurance Company (ies), and their agents in order to obtain payment for services and determine insurance benefits payable for services.

Patient Name: _____ Date: _____

Signature Patient or Guardian: _____

Name and Relation to Patient if signed by Guardian: _____

PURE DENTAL

Dawn C. Baker, DDS

PURE DENTAL
Dawn C. Baker, DDS

FINANCIAL & CANCELLATION POLICY

Thank you for choosing Pure Dental as your dental health care provider. We are committed to providing you with the highest quality dental care using only the best technology and materials available in the market today. Dental treatment is an investment in an individual's medical care and emotional well-being. In our office, we strive to help you utilize your insurance benefits and make any remaining balance affordable.

PAYMENTS
We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, American Express and Care Credit. We do not accept personal checks over the amount of $750. Returned checks are subject to a $35 fee due to bank policies.
Payments are due at the time of service.

MINOR PATIENTS
Parents and/or Guardians of minor patients are responsible for payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless payment has been made or arranged at the time of service.

PAYMENT PLANS
Pure Dental has partnered with Care Credit, a patient financing company, to offer our patients 0% (interest deferred) financing for 6 months, pending credit approval, as well as other payment plans (minimums apply, ask for more details).

MISSED APPOINTMENTS & FEE
We reserve special time just for you in our office. We try to avoid late cancellations to best accommodate all of our patients. If you find that you must change your appointment, you must notify us 2 business days in advance. **If the 2-business day notice is not received, a fee of $50.00 may be charged.**

BILLING
We do our best to make you aware of your estimated fee for service. You will be responsible for any remaining balance after insurance (if applicable).

Accounts, which have not been paid at the time of service, will incur a $3.00 administrative charge as well as monthly 1.5% finance charge (18% APR) after 30 days.

Any account that has not been paid in full within 60 days may be handed over to a collection agency who will pursue the responsible party for reimbursement. This may negatively impact your credit history and limit the treatment you can receive at our office.

REFUNDS
Refunds for overpayments will be made after all treatment is completed and insurance payments have been collected. Refunds will be returned in the same form payment was made.

Thank you for understanding our Financial Policy. Please speak with a staff member if you have any questions.

I understand and agree to the terms of this Financial Policy and Cancellation Policy.

Patient Name: _____

Patient Signature (if over 18): _____ Date: _____

If patient is a minor:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

PURE Dental, Dawn C. Baker, DDS

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
(See front desk for the full version of HIPAA Policy)

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/02/2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us or see someone at the Front Desk.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I give Pure Dental and its employees permission to contact me regarding my dental care via the following methods. If you do not want to be contacted via one of these methods, please let us know.

- E-mail
- Mobile # & voicemail
- Home # & voicemail
- Work # & voicemail
- Text Message

I authorize Pure Dental to contact and disclose necessary health information as needed:

____ Spouse/Family Member: _____
____Emergency Contact: _____
____ Other: _____

I have been given the opportunity to review The Notice of Privacy Practices and acknowledge its contents.

Print Name:_____Date: _____

Signature:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (Please Specify)_____