1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: __/__/__ Age: _____ SS #: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____) _____ Pager / Cell #: _____

Wk #: (____) _____ Ext: ____ DL #: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Contact #: (____)_____ Ext: ____ SS #: _____

Person Responsible for Account: _____

Contact #: (____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

4 Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription / over-the-counter or supplemental drugs?

Please list each one: _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y N	Anemia	Y N	Heart Surgery / Pacemaker
Y N	Artificial Bones	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Joints	Y N	Hepatitis C
Y N	Artificial Valves	Y N	High Blood Pressure
Y N	Arthritis	Y N	HIV+ / AIDS
Y N	Asthma	Y N	Hospitalized for Any Reason
Y N	Blood Transfusion	Y N	Kidney Problems
Y N	Cancer / Chemotherapy	Y N	Low Blood Pressure
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Treatment
Y N	Difficulty Breathing	Y N	Radiation Treatment
Y N	Drug / Alcohol Abuse	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema	Y N	Severe / Frequent Headaches
Y N	Epilepsy / Seizures	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease / Traits
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Glaucoma	Y N	Thyroid Problems
Y N	Heart Attack / Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers / Colitis

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs / materials that you are allergic to: _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

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FINANCIAL POLICY:

FOR YOUR CONVENIENCE, WE OFFER MULTIPLE FORMS OF PAYMENT: CASH, CHECK, VISA, MASTERCARD, AMEX, DISCOVER, CARECREDIT AND LENDING CLUB.

PAYMENT IS DUE AT THE TIME OF SERVICE.

PATIENT IS RESPONSIBLE FOR ALL CHARGES. IF PATIENT'S ACCOUNT BALANCE IS NOT PAID IN FULL WITHIN 90 DAYS, WE RESERVE THE RIGHT TO SEND THE ACCOUNT TO A COLLECTION AGENCY.

FACTS ABOUT INSURANCE:

• Your dental benefit program is a contract between you, your employer and the insurance company. **WE ARE NOT PART OF THAT CONTRACT.** In addition, it is your responsibility to determine if our office is in or out of network with your insurance.

• Dental insurance is not meant to be a PAY-ALL, it is only meant to be an aid.

• Our fees are generally, but not always, covered in full by the maximum allowance determined by your carrier. Many plans tell their insured that they will be covered up to 80% or up to 100% but do not clearly specify the plan's fee scheduled allowance, annual maximum or limitations.

• It has been the experience of many dentists that insurance companies occasionally tell their insurance that "the fees charged were above the usual and customary rate", rather than saying "the insurance benefits are low."
• Many routine dental services are **NOT** covered by insurance carriers.

• YOU ARE RESPONSIBLE TO US FOR ALL FEES FOR SERVICES RENDERED. IF YOUR INSURANCE COMPANY HAS NOT PAID ON YOUR CLAIM WITHIN 30 DAYS, IT IS YOUR RESPONSIBILITY TO SEE WHY THE CLAIM HAS NOT BEEN PAID, AND YOUR BALANCE IS DUE IN FULL. OUR STAFF WILL BE GLAD TO ASSIST YOU IN ANY WAY THEY CAN REGARDING YOUR INSURANCE CLAIM RECOVERY.

Patient's Signature:_____Date:_____
Parent/Guardian's Signature (if patient is a minor): _____

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Robert Baumann, DDS • Ashley Lanman, DDS • Kristie Haller, DDS

Bryce Baumann, DDS • Darrell Guttery, DDS

HIPAA CONSENT

MY SIGNATURE ON THIS FORM INDICATES THAT I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR MY TREATMENT, PAYMENT AND OPERATIONAL USE. IF I HAVE ANY QUESTIONS, I KNOW I CAN CONTACT THE PRIVACY OFFICER FOR THIS OFFICE. I HAVE BEEN ADVISED THAT A NOTICE OF PRIVACY PROTECTIVE PRACTICES PAMPHLET IS AVAILABLE TO ME UPON REQUEST.

LIST THE NAMES OF ANYONE WE CAN RELEASE INFORMATION TO:

NAME:_____

RELATIONSHIP TO YOU: _____

IS IT OKAY TO LEAVE A MESSAGE ON YOUR VOICEMAIL? _____

IS IT OKAY FOR OUR OFFICE TO SEND YOU AN EMAIL? _____

SIGNATURE: _____DATE: _____

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