Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (Confidential)

Name _____ Birthday _____ Home Phone _____
Address _____ City _____ State_____ Zip _____
Phone # _____ Soc. Sec. # _____ Today's Date _____
Cell Phone _____ Email _____
Driver's License # _____ State Issued _____ Exp. Date_____
Check Appropriate Box: ☐ Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Employer _____ Work Phone _____
Business Address _____ City_____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Who may we thank for referring you? _____
Person to Contact in Case of Emergency _____ Phone # _____

RESPONSIBLE PARTY (if same as above, leave blank)

Name of Person Responsible for this Patient _____ Relationship to Patient _____
Address _____ Home Phone _____
Driver's License # _____ State Issued _____ Expiration Date_____
Employer _____ Work Phone _____ S.S. # _____
Is this person currently a patient in our office? ☐ YES ☐ NO
For your convenience, we offer the following methods of payment. Please check the option you prefer. Pay is due in full at each appointment. ☐ Cash ☐ Personal Check ☐ Credit Card ☐ I wish to discuss the office's payment policy and financing.

DENTAL INSURANCE INFORMATION (Not medical)

Policy Holder Name _____ Relationship to Patient _____
Birthdate _____ S.S # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State_____ Zip_____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State_____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? (Dual Coverage) ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Policy Holder Name _____ Relationship to Patient _____
Birthdate _____ S.S # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State_____ Zip_____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State_____ Zip _____

DENTAL INFORMATION

Are you having pain or discomfort at this time? □ YES □NO Is your mouth dry? □ YES □NO
Does food or floss catch between your teeth? □ YES □NO Do you wear dentures or partials? □ YES □NO
Do you have sores or ulcers in your mouth? □YES □NO Have you had orthodontic Treatment □YES □NO
Have you had any periodontal (gum) treatment? □YES □NO Do you have any dental implants □YES □NO
Have you had any problems associated with previous dental treatment? □YES □NO
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? □YES □NO
Name of Physician/Dentist Making Recommendation _____ Phone #_____

MEDICAL INFORMATION

Have you been hospitalized in the last two years? □YES □NO Are you under the care of a physician? □YES □NO
Physician's Name _____ Phone #_____Address_____
List of Conditions Being Treated _____
Current List of Medications _____
Are you sensitive or allergic to any medication or anesthetics? □ YES □NO, If yes, please list _____
_____

Indicate which of the following you have had or have at present. Check "YES" or "NO" to each item.

Heart Failure □YES □NO	Artificial Joints (hip, knee, etc.) □YES □NO	Hepatitis B (Serum) □YES □NO
Heart Disease/Attack □YES □NO	Kidney Trouble □Yes □NO	Venereal Disease □YES □NO
Angina Pectoris □YES □NO	Ulcers □Yes □NO	A.I.D.S □YES □NO
Cardiovascular Disease □YES □NO	Diabetes □YES □NO Type:_____	H.I.V Positive □YES □NO
Heart Murmur □YES □NO	Thyroid Problems □YES □NO	Cold Sores/Fever Blisters □YES □NO
High Blood Pressure □YES □NO	Low Blood Pressure □YES □NO	Glaucoma □YES □NO
Blood Transfusion □YES □NO	Arteriosclerosis □YES □NO	Emphysema □YES □NO
Hemophilia □YES □NO	Anemia □YES □NO	Cancer □YES □NO
Chemotherapy □YES □NO	Radiation Treatment □YES □NO	Mitral Valve Prolapse □YES □NO
Artificial Heart Valve □YES □NO	Chronic Cough □YES □NO	Sickle Cell Disease □YES □NO
Heart Pacemaker □YES □NO	Tuberculosis □YES □NO	Bruise Easily □YES □NO
Heart Surgery □YES □NO	Asthma □YES □NO	Liver Disease □YES □NO
Rheumatic Fever □YES □NO	Hay Fever □YES □NO	Yellow Jaundice □YES □NO
Arthritis □YES □NO	Allergies or Hives □YES □NO	Epilepsy or Seizures □YES □NO
Rheumatism □YES □NO	Sinus Trouble □YES □NO	Fainting or Dizzy Spells □YES □NO
Cortisone Medicine □YES □NO	Nervousness □YES □NO	Drug Addiction □YES □NO
Tumors □YES □NO	Stroke □YES □NO	Hepatitis A (infectious) □YES □NO

For Women only:

Are you pregnant? □YES What Month? _____ □NO Are you Nursing? □YES □NO
Are you taking birth Control Pills? □YES □NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

AUTHORIZATION AND RELEASE

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS
2. ENSURE PAYMENT FOR SERVICES PROVIDED
3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
4. RELEASE INFORMATION TO AND FROM OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services.

I attest to the accuracy of the information on this page.

Patient Signature _____ Date _____
(or parent if minor)

Kenneth W. Baker, D.D.S., P.A.

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 THIS FORM CAREFULLY.

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 01/01/13, 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 using the information listed at the end of this Notice.

HOW WE MAY DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment for you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, and insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

In**dividuals Involved in Your Care or payment for your care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by law. We may use or disclose your health information for public health activities, including disclosures to: prevent or control disease, injury, or disability. To report child abuse or neglect, report reactions to medications or problems with products or devices, notify a person of a recall, repair, or replacement of products or devices, notify a person who may have been exposed to a disease or condition, or to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

You May Refuse to Sign This Acknowledgement

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

Print name: _____

Signature: _____

Date: _____

For Office Use Only

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

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

_____
_____
_____