



WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.

The better we communicate, the better can care for you and your smile!

1 ABOUT YOU

Name _____

Preferred Name _____

Male Female Unspecified

Single Married Divorced Widowed Separated

Birth Date _____ Age _____

SS# _____

Address _____

City _____ State _____ Zip _____

Email _____

Home # _____ Work # _____

Cell# _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Last dental cleaning/visit date _____

Employer _____

Employer Ph.# _____

Employer Address _____

2 INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Phone # _____

Group # _____

Subscriber ID # _____

Insured's Birth Date _____

Insured's Phone # _____

Insured's SS # _____

***ID # is sometimes different than SS#.*

IF YOU HAVE A SECONDARY INSURANCE POLICY, PLEASE LET A TEAM MEMBER KNOW.

3 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Cell # _____ Birth Date _____

Email _____

Male Female Unspecified

Thank you for filling this form out completely. It will allow us to serve you more effectively.

If you have questions at any time, please ask us. We are happy to help!

4 ACKNOWLEDGEMENTS

Financial Policy

Patient responsibility plays a big role in successful treatment. Attending scheduled visits and performing dental home care recommendations resulting in a winning smile for years to come.

- Accounts are due and payable at the time of service unless other arrangements have been made with our Office Manager.
 - For patients with insurance, we will gladly bill your insurance for you as a courtesy, when you provide the necessary information. We will accept payment directly from the insurance company only for that percentage the company has estimated to cover. Insurance companies are usually clear when they provide information regarding your coverage. They use a disclaimer that states, "all claims are subject to eligibility and plan provisions at the time the services are rendered. This is not a guarantee of coverage". We do our best to contact your insurance company and get an insurance breakdown of your policy. With this information, we can estimate your benefits and your cost portion. However, we encourage you to become familiar with your insurance benefits to ensure you understand the details of your policy. We require that you pay for the deductible and any non-covered fees at the time services are provided.
 - **We require a 24-hour notice for any appointment cancellation. Failure to provide 24-hour notice of cancellation may result in a minimum \$35 cancellation fee.** Thank you for your cooperation in advance.
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I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges is not made, I agree to pay all cost of collection including a 50% collection fee, attorney fees, and court costs.

Print Name _____ Signature _____ Date _____



BAILEY

family dentistry^{LLC}

Medical Health History

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Corticosteroid Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
			Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how **Bailey Family Dentistry, PLLC** may use and disclose your protected health information and when we need your written authorization to do so. This form complies with the HIPAA Privacy Standards and 42 CFR Part 2.

Name of Patient (print): _____ Date of Birth: _____

I. My Authorization

I authorize **Bailey Family Dentistry, PLLC** to use or disclose the following health information:

- ☐ I authorize the use or disclosure of my records, including any Substance Use Disorder (SUD) records, for all current and future Treatment, Payment, and Health Care Operations (TPO) as permitted by law.
- ☐ All of my health information
- ☐ Specific treatment or condition: _____.
- ☐ Specific date range: From _____ (Start Date) to _____ (End Date).

The above party may disclose this health information to the following recipient:

Name/Organization: _____

Phone: _____ Fax: _____ Email: _____

II. State Law and Sensitive Information

In some cases, state or other federal laws provide greater privacy protections for specific types of "sensitive" health information. I understand that I may choose not to initial any of the categories below, and my refusal to sign will not affect my ability to receive treatment (unless the authorization is specifically required for research-related care or to create information for a third party).

By initialing below, I specifically authorize the release of information related to:

- ____ Reproductive Health (Abortion/Contraception)
- ____ Infectious Disease (HIV/AIDS testing/treatment)
- ____ Mental Health: (Treatment/Genetic Testing)
- ____ Substance Use Disorder (SUD Records)

Note: When stricter laws apply, we follow the law providing you with the most protection.

III. Purpose of This Authorization

The purpose of this authorization is (check all that apply):

- ☐ At my request.
- ☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ☐ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

☐ Other: _____

IV. Legal Protections and My Rights

- Legal Proceedings Prohibition: Records received from programs subject to 42 CFR Part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against me without my specific written consent or a court order.
- Right to Revoke: I may revoke this authorization in writing at any time, except where disclosures have already been made based on my original permission.
- Redisclosure: Information disclosed with my permission may be re-disclosed by the recipient and may no longer be protected by federal privacy laws.
- SUD Counseling Notes: A separate, standalone consent is required for the release of any SUD Counseling Notes (kept separate from the medical record).
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

V. Expiration and Revocation

This authorization remains in effect until the following date or event:

- ☐ On (Date): _____
- ☐ When I am no longer a patient of the practice.
- ☐ Other: _____.

VI. Signatures and Acknowledgements

By signing below, I acknowledge the following:

1. Authorization: I authorize the release of all information checked in Sections I, II, and III.
2. Rights: I understand my right to revoke this in writing and the prohibition of use in legal proceedings.
3. Condition of Care: My treatment is not conditioned upon signing this authorization.
4. Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices and have read and understood its content.

Patient Name (print): _____ Date of Birth: _____

Signature (Self/Parent/Guardian): _____ Date: _____ (If signed
by a Representative, state authority: _____).