

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!

| Name_ | | | | | |
|---------------|------------------------------------|--|--|--|--|
| Preferr | ed Name | | | | |
| | Male Female Unspecified | | | | |
| Single | Married Divorced Widowed Separated | | | | |
| Birth Da | ateAge | | | | |
| SS# | | | | | |
| Addres | S | | | | |
| City | StateZip | | | | |
| Email_ | | | | | |
| Home # Work # | | | | | |
| Cell# | | | | | |
| | may we thank for referring | | | | |
| | family members seen by | | | | |
| Last de | ntal cleaning/visit date | | | | |
| Employ | /er | | | | |
| Employ | /er Ph.# | | | | |
| Employ | ver Address | | | | |

ABOUT YOU

| (2) | INSURAN | ICE |
|---------------|--------------------------------------|---------------|
| Provider Na | me | |
| | dress | |
| | State | |
| Phone # | | |
| Group # | | |
| Subscriber II | D# | |
| Insured's Bir | rth Date | |
| Insured's Ph | one # | |
| Insured's SS | # | |
| **ID # i | s sometimes differ | ent than SS#. |
| | IAVE A SECONDAR FASE LET A TEAM I | |

| 3 ACCOUNT INFO | | | | | | | | | |
|--------------------------------|--|--|--|--|--|--|--|--|--|
| PERSON RESPONSIBLE FOR ACCOUNT | | | | | | | | | |
| Relation | | | | | | | | | |
| /ork # | | | | | | | | | |
| Cell # Birth Date | | | | | | | | | |
| | | | | | | | | | |
| Unspecified | | | | | | | | | |
| | | | | | | | | | |





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.

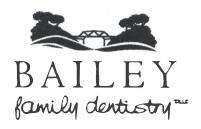
Notice of Privacy Practices- HIPAA

It is the policy of Bailey Family Dentistry, PLLC to maintain the privacy of all patients' transactions. Bailey Family Dentistry, PLLC is hereby authorized to release any medical or incidental information that may be necessary for medical care or in processing requests for financial benefits. A copy of our Privacy Policy is available for your review.

By law, Bailey Family Dentistry, PLLC can discuss or give information regarding your care only to persons you

designate to us. Please list those persons with whom we may discuss your care today or in the future.

| Name: | Relationship: | |
|--|---|------------------------------------|
| Name: | Relationship: | |
| I understand that the information I have give this information will be held in the strictest changes in my medical status. I authorize the during diagnosis and treatment with my information | of confidence and it is my responsible dental team to perform any necessary | ility to inform this office of any |
| In the event that payment in full for charges is fee, attorney fees, and court costs. | not made, I agree to pay all cost of coll | ection including a 50% collection |
| Print Name Signa | ature | Date |



Medical Health History

| Albha e e e a cara | | | | | | | - M |
|--|--|--|---|---|--|--|---|
| | , | | | , your mouth is a part o ationship with the denti | • | | |
| Have you ever been he Have you eve Are you tak Do you take | espitalized or had ir had a serious h ing any medication ave you taken, Pl | a major operation? ead or neck injury? ons, pills, or drugs? hen-Fen or Redux? | Yes No If Yes No If Yes No If Yes No If | yes, please explain: _ yes, please explain: _ yes, please explain: _ yes, please explain: _ | | | |
| other medic | ations containing Are you Do Do you use cont | g bisphosphonates? Upon a special diet? Upon a special diet? Upon use tobacco? Uponled substances? Uponled substances? | Yes No Yes No Yes No | Strange Very Alla | Niveria - 0 | O Voc O No | |
| Pregnant/Trying to g Are you altergic to a | | | ig oral contracep | tives? Yes No | Nursing? | ○ Yes ○ No | |
| Aspirin Other If yes, pl | Peniciffin [| Codeine L | ocal Anesthetics | Acrylic | Metal | Latex | Sulfa drugs |
| Do you have, or have AIDS/AIV Positive AIDS/AIV Positive AIZheimer's Disease Arephylaxis Anemia Angima Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Disease Blood Transfusion Breathing Problem Bruse Easily Cancer Chemotherapy Chast Pains Cold Sures/Fever Blister Congenital Heart Disord Convulsions | Yes No | f the following? Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizzines Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease | Yes No | Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoghyamia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Protapse Octeoporosis Pain in Jaw Joints Parathyroid Disease | Yes No | Radiation Treatments Recent Weight Loss Renal Dialysis Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Dis Stroke Swelling of Limbs Thyroid Disease Tonsilitis Tubercalosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice | Yes Yes |
| Comments: | owledge, the ques | | e been accuratel | y answered. I understatal office of any change | | • | ation can be |