



PATIENT INFORMATION

FULL LEGAL NAME + PREFERRED NAME	
DATE OF BIRTH	
PREFERRED PRONOUNS (He/She/They/Them)	
ADDRESS	
HOME NUMBER	
CELL NUMBER	
EMAIL ADDRESS	
EMERGENCY CONTACT NAME + NUMBER	
ARE YOU FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? If Power of Attorney is utilized, we will require a copy of the POA to be on file.	YES / NO <i>If not, please list the responsible party's contact info + relationship to patient:</i>
HOW DID YOU HEAR ABOUT OUR OFFICE? If a friend referred you, please name them so we can thank them!)	

FINANCIAL AGREEMENT:

Do you have Dental Insurance?

YES / NO

In person, please provide us with your card, name, and birthdate of the policyholder as well as Employer Name, Group Name and/or Group Number, and Member ID. We will create an insurance claim for you to submit in a stamped envelope provided by our office. Any reimbursement due from your dental insurance policy will be sent directly to the patient/policyholder.

*** We do not contract with any dental insurance companies and insurance is not an accepted form of payment ***

*I understand that **payment in full is due to Baylee Dental at the time of service, regardless of any dental plans.** Baylee Dental accepts debit, credit, cash, check, Care Credit, & Lending Club as authorized forms of payment.*

Patient/Legal Representative Signature / Date:

BAYLEE DENTAL HEALTH HISTORY

Although dental personnel primarily treat the area in and around the mouth, your mouth can significantly affect your entire body. Health problems that you may have and medications you may be taking can greatly impact your overall dental health.

Are you under the care of a physician for any reason? Y / N _____

Have you even been hospitalized or undergone surgery? Y / N _____

Have you even had a head or neck injury? Y / N _____

Are you taking any medications, prescribed or over the counter? Y / N _____

Do you take, or have you ever taken, Phen-Fen or Redux? Y / N _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y / N _____

Are you on a special diet? Y / N _____

Do you use tobacco? Y / N _____

Do you use controlled substances? Y / N _____

* Women: (please circle) **Are you pregnant?** Y / N **Nursing?** Y / N **Taking oral contraceptives?** Y / N

Are you allergic to any of the following? (please circle any / all that apply):

Aspirin Penicillin Codeine Acrylic Metal(s) Latex Sulfa drugs Local Anesthetics? Other:

Do you have, or have you ever had any of the following conditions? (Please circle any / all that apply):

AIDS/HIV positive	Cortisone Medication	Hemophili a	Radiation Treatment
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B/C	Renal Dialysis
Anemia	Easily winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis / Gout	Epilepsy / Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting / Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach / Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsilitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores	Heart Murmur	Pain in Jaw Joints	Tumors/Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble	Psychiatric Care	Venereal Disease
			Yellow Jaundice

Signature: _____

Date: _____

Notice of Privacy Practices Baylee Dental

How we protect your information and privacy

Your Rights:

***Get an electronic or paper copy of your medical record**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee.

***Ask us to correct your medical record**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

***Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

***Ask us to limit what we use or share**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are **not** required to agree to your request, and we may say “no” if it would affect your care. **MINORS:** In the case of a minor child where the parents are divorced, we will request a copy of the divorce decree and we will abide by that order. If there is no decree, then we will treat both parents equally and will share information when it is requested. We may or may not advise the other parent that a request for information has been made.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

*** Get a list of those with whom we’ve shared information**

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable fee if you ask for another one within 12 months.

*** Get a copy of this privacy notice**

You may receive a written copy of this notice.

*** Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

*** File a complaint if you feel your rights are violated**

You can complain if you feel we have violated your rights by contacting us at Baylee Dental or by contacting the Office of Civil Rights www.hhs.gov/ocr/privacy/hipaa/complaints

Your Choices:

In certain situations, or conditions, you can tell us your choices about what we can share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will try to follow your instructions.

- In these cases, you have both the right and choice to tell us to:
- Share information with family or close friends involved in your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference or in the event of an emergency, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- We will never share your information for: marketing, fundraising, or profit.

Our Uses

- Treat You:
We can use your health information and share it with other professionals who are treating you including other dentist and healthcare professionals such as your Cardiologist, Family Physician, etc.
- Run our organization:
We can use and share your health information to run our practice, improve your care, and contact you when necessary and as necessary.
- Bill for our services:
We can use and share your health information to seek payment from health plans, benefit providers or other entities.

How else we can use your information?

We are allowed to use your information in other situations or ways that usually affect the public good.

- We can share health information about you for certain situations such as:
 - *Preventing diseases
 - *Helping with product recalls
 - *Reporting adverse reactions to medicines
 - *Reporting suspected abuse, neglect, or domestic violence
 - *Preventing or reducing a serious threat to anyone's health or safety
 - * Research purposes
 - *To comply with state or federal laws
 - *To respond to a court order or subpoena
 - *Share with coroner or medical examiner or funeral home
 - *In the event of an emergency or disaster
 - *Workers Compensation Claims
 - *For law enforcement purposes
 - *For special government functions such as military or national security

Our Responsibilities

We take patient privacy very seriously and attempt to take every precaution and safeguard to protect our patient's health information. However, if we find that there has been a breach or misuse of your information, we will notify you as soon as possible. Please direct Privacy and Security questions to:

Catherine Baitinger, Privacy and Security Officer
16850 S HWY 441, Suite 301
Summerfield, FL 34491
(352) 307-3006

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS NEEDED AND FOR USES AS DESCRIBED IN THIS FORM.

Patient/Legal Guardian Name: _____

Signature: _____

Date: _____



Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Please do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

1. EXAMINATION AND X-RAYS I understand that the initial visit and annual exam may require radiographs in order to properly complete the examination, determine proper diagnosis, and to create a personalized treatment plan.

_____ Please Initial

2. DRUGS, MEDICATION, AND SEDATION I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

_____ Please Initial

3. CHANGES IN TREATMENT PLAN I understand that during treatment, it may be necessary to change or add procedures because found while working on teeth that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any necessary changes and/or additions to my treatment plan based off the professional opinion of the Dentist and in alignment with current diagnosing guidelines and protocols, and the current standards of care.

_____ Please Initial

4. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ) I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually temporary in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment, the cost of which is my responsibility.

_____ Please Initial

5. FILLINGS AND RESTORATIONS I understand that care must be exercised in chewing on the new filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling.

_____ Please Initial

6. CROWNS, BRIDGES, VENEERS, AND BONDING I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or veneer (including shape, fit, size, placement, and color) will be done before cementation. It explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

_____ Please Initial

7. ENDODONTIC TREATMENT (ROOT CANAL) I realize there is no guarantee that root canal treatment will save my tooth should I be diagnosed with an endodontic concern, and that complications can occur after endodontic treatment; occasionally posts are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment but that my dentist has recommended this treatment in good faith of a good prognosis based off current diagnosing guidelines and protocols, and the current standards of care.

_____ Please Initial

CONSENT: I acknowledge that no guarantee or assurances can be made by anyone regarding any dental treatment which I have requested and/or authorized. I understand that each dentist is an individual practitioner at Baylee Dental, PA and each provider is individually responsible for the dental care rendered to me. I also understand that no other dentist, other than the treating dentist, is responsible for my dental treatment. This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain your dentist has addressed all your concerns to your satisfaction prior to starting treatment.

***Disclaimer: Consent forms for Oral Surgery procedures and the fabrication of crowns, bridges, dentures, etc. will be provided on a case-by-case basis prior to the commencement of the procedures.*

Patient/Legal Guardian Name: _____

Signature: _____

Date: _____



**Dr. Catherine Baitinger
Privacy Officer for Baylee Dental
(352) 307-3006**

AUTHORIZATION FOR RELEASE OF PERSONAL & PROTECTED HEALTH INFORMATION

I authorize Baylee to **release** health information identifying me under the following terms and conditions:

At my request, I hereby authorize the use and disclosure of the patient information as described below **to another person listed below**: (please print)

1. Name: _____

Relationship: _____ **Phone # if different than patient** _____
Address (if different than patient): _____

_____ **Expiration date:** _____

2. Name: _____

Relationship: _____ **Phone # if different than patient** _____
Address (if different than patient): _____

_____ **Expiration date:** _____

The request and authorization applies to all healthcare information, financial, and confirmations and can be sent directly to any providers' office to which you may be referred. Limit information relating to the following treatment conditions or dates:

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the Privacy Officer listed at the top of this form.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Legal Guardian Name: _____

Signature: _____

Date: _____



Appointment Cancellation Policy

Baylee Dental is exercising the right to request our patients to **provide at least 48-hours' notice** (two business days) if an appointment needs to be canceled or rescheduled. This window of time allows us to contact and appoint other patients who are actively seeking sooner availability with our Dentists and/or Hygienists. Exceptions may be available but must be addressed at the time of cancellation and are approved on a case-by-case basis. Canceling, rescheduling, or no-showing for appointments without providing at least 48-hours' notice will be considered a "Failed Appointment" for which a \$25 fee will be assessed; this fee cannot be billed to your dental plan as it is the direct responsibility of the patient.

If you have any questions regarding this policy, please contact us at your earliest convenience. We thank you for your continued patronage and we look forward to seeing you at your next visit!

I have read and understand the Appointment Cancellation Policy of Baylee Dental and I agree to its terms. I also understand and agree that such terms may be amended from time-to-time by the practice and that I can request updated policy information at my convenience.

Patient/Legal Guardian Name: _____

Signature: _____

Date: _____