Baker & Graham
FAMILY DENTISTRY

WELCOME TO THE OFFICE OF

William C. Baker, Jr. D.D.S. P.A., Erik G. Graham D.M.D. P.A.

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 complete this form in ink. If you have any questions or need assistance, please ask us ~ we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Date _____

PATIENT:

First Name _____ Middle Name _____ Last Name _____

Preferred Name to be called (Nickname) _____ Soc. Sec. # _____

Mailing Address _____ Street Address _____

E-mail _____ City _____ State ____ ZipCode _____

Home Phone ( ) _____ Cellular Phone ( ) _____

Date of Birth _____ Age _____ Marital Status _____ Sex _____

Employer _____ Occupation _____

Employer Address _____ Work Phone ( ) _____

How did you hear about our practice? _____

PATIENT'S SPOUSE:

Name _____ Soc. Sec. # _____ Date of Birth _____

Employer's Name _____ Occupation _____ Work Phone ( ) _____

Employer's Address _____ City _____ State _____ Zip Code _____

EMERGENCY INFORMATION:

Name of someone <u>not living</u> with you (in case of emergency).

Name _____ Phone ( ) _____

Address _____ Relationship _____

• PLEASE COMPLETE SECTION BELOW IF PATIENT IS MINOR OR STUDENT •

PATIENT'S FATHER:

Father's Name _____ Father's Date of Birth _____

Father's Home Address _____

Father's Email _____

Father's Home Phone ( ) _____ Father's Work Phone ( ) _____ Father's Soc. Sec. # _____

Father's Employer _____ Occupation _____

Father's Employer's Address _____ City _____ State _____ Zip Code _____

PATIENT'S MOTHER:

Mother's Name _____ Mother's Date of Birth _____

Mother's Home Address _____

Mother's Email _____

Mother's Home Phone ( ) _____ Mother's Work Phone ( ) _____ Mother's Soc. Sec. # _____

Mother's Employer _____ Occupation _____

Mother's Employer's Address _____ City _____ State _____ Zip Code _____

INSURANCE INFORMATION:

Do you have dental insurance? ❑ yes ❑ no ***If yes,*** please provide us with your dental insurance card.

PATIENT DENTAL HISTORY:

Name of previous dentist _____ City _____ State _____ Phone Number _____

1. Please check any of the following problems that apply to you.

	Yes	No
Sensitivity/Pain (e.g. hot, cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
Headaches, earaches, neck pain	☐	☐
Jaw joint pain	☐	☐
Teeth or fillings breaking	☐	☐
Grinding or clenching teeth	☐	☐
Difficulty in chewing	☐	☐
Bleeding, swollen or irritated gums	☐	☐
Difficulty in opening/closing	☐	☐
Loose, tipped or shifting teeth	☐	☐
Bad breath	☐	☐
2. Do you have or have you had any of the following?	☐	☐
Dentures	☐	☐
Partial dentures	☐	☐
Braces	☐	☐
Periodontal (gum) treatments	☐	☐
Any sores or lump in or near your mouth	☐	☐
Any diffcult extractions in the past	☐	☐
Any prolonged bleeding following extractions	☐	☐
3. Do you smoke or use chewing tobacco?	☐	☐

How much? _____ *How long?* _____

4. Please share the following dates:
   - *-Your last cleaning* ____ /____
   - *-Your last oral cancer screening* ____ /____
   - *-Your last complete X-rays* ____ /____

5. If I could change my smile, I would:	Yes	No
Make it whiter	☐	☐
Make it straighter	☐	☐
Close spaces	☐	☐
Make teeth longer	☐	☐
Change the shape of the teeth	☐	☐
Replace black metal fillings with tooth colored restorations	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Replace old crowns that don't match	☐	☐
Have a smile makeover	☐	☐

6. On a scale of 1-10, with 10 being the highest rating:
   - *How important is your dental health to you?* 1 2 3 4 5 6 7 8 9 10
   - *Where would you rate your current dental health?* 1 2 3 4 5 6 7 8 9 10
   - *Where do you want your dental health to be?* 1 2 3 4 5 6 7 8 9 10

7. *Why did you leave your previous dentist?* _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

PATIENT MEDICAL HISTORY:

Name of family physician _____ City _____ State _____ Phone Number _____

1. Please check any of the following problems/conditions that apply to you:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Respiratory problems	☐	☐
Allergies (seasonal)	☐	☐	Dizziness	☐	☐	HIV positive	☐	☐	Rheumatic fever	☐	☐
Anemia	☐	☐	Drug addiction	☐	☐	HPV (human papilloma virus)	☐	☐	Rheumatism	☐	☐
Angina (chest pain)	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Scarlet fever	☐	☐
Arthritis	☐	☐	Epilepsy	☐	☐	Jaw joint pain	☐	☐	Seizures	☐	☐
Artificial heart valve	☐	☐	Excessive bleeding	☐	☐	Kidney disease	☐	☐	Sinus problems	☐	☐
Artificial joints	☐	☐	Fainting	☐	☐	Liver disease	☐	☐	Sleep apnea	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Low blood pressure	☐	☐	Stomach problems	☐	☐
Blood disease	☐	☐	Heart conditions	☐	☐	Mitral valve prolapse	☐	☐	Stroke	☐	☐
Breastfeeding (currently)	☐	☐	Heart lesions (congenital)	☐	☐	Nervousness/depression	☐	☐	Thyroid disease	☐	☐
Bruise easily	☐	☐	Heart murmur	☐	☐	Osteoporsis	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Heart surgery	☐	☐	Pacemaker	☐	☐	Ulcers	☐	☐
Cervical cancer	☐	☐	Hepatitis A	☐	☐	Pregnant (currently)	☐	☐	Venereal diseases	☐	☐
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Radiation (head/neck)	☐	☐	Other _____		
Cortisone medication	☐	☐	Hepatitis C	☐	☐	Reflux	☐	☐	_____		

2. Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No		Yes	No		Yes	No		Yes	No
Aspirin	☐	☐	Hydrocodone	☐	☐	Penicillin	☐	☐	Valium	☐	☐
Clindamycin	☐	☐	Latex	☐	☐	Percodan	☐	☐	Any metals (nickel, mercury, etc.)	☐	☐
Codeine	☐	☐	Local Anesthetic	☐	☐	Sulfa	☐	☐	Other _____		
Halcion	☐	☐	Nitrous Oxide	☐	☐	Tetracycline	☐	☐	_____		

3. Have you ever taken any of the following medications for osteoporsis?

	Yes	No		Yes	No
Actonel	☐	☐	Herbal Supplements	☐	☐
Aredia	☐	☐	Reclast	☐	☐
Boniva	☐	☐	Zometa	☐	☐
Fosamax	☐	☐	Other _____		

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand a finance charge will be added to my account monthly on balances over 90 days. I understand if not paid I will be responsible for all collection cost, court cost, attorney fees and any additional delinquent billing fees or processing fee and interest of 1.5% monthly up to 18% annual interest.

_____ _____ _____

Patient Signature (parent if child) *Date* *Witness Signature*

Consent to Perform Dentistry

Baker & Graham
FAMILY DENTISTRY

1 I hereby authorize and direct the dentist(s) of Baker & Graham and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

- **A** • Preventative hygiene treatment (prophylaxis) and the application of topical fluoride.
- **B** • Application of plastic "sealants" to the grooves of the teeth.
- **C** • Treatment of diseased or injured teeth with dental restorations (fillings or crowns).
- **D** • Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
- **E** • Removal (extraction) of one or more teeth.
- **F** • Treatment of diseases or injured oral tissues (hard and/or soft).
- **G** • Use of sedative drugs to control apprehension and/or disruptive behavior.
- **H** • Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
- **I** • Use of general anesthesia to accomplish the necessary treatment.

2 I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3 I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves and indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the risks and complications.

4 I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and wellbeing in the professional judgement of the dentist.

5 There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respirator and cardiovascular collapse (stopping of breathing and heart funciton) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6 I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7 I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8 I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9 I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date:_____ Time:_____ AM/PM File #:_____

Patient's Name: _____

Name of Parent or Guardian:_____ Relationship to Patient:_____

_____ _____

Signature of Patient/Parent/Guardian Witness

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FINANCIAL GUIDELINES

_____ I understand that payment is due at the time service is provided. Our office accepts cash, personal checks and all major credit cards. Outside financing is available upon request and approval. Please let us know if you would like more information about financing options.

_____ I understand that a finance charge of 1.5% monthly up to 18% annual interest will be added to my account monthly if my account is delinquent . I understand that if not paid my account will be turned over to the Credit Bureau and I will be responsible for all collection cost, court cost, attorney fees and any additional delinquent billing fees or processing fee.

_____ I understand that return checks will be subject to additional fees

AUTHORIZATION TO DISCLOSE PROTECTED DENTAL INFORMATION AND ACCOUNT INFORMATION

I authorize Baker & Graham Dental to discuss my dental treatment or my account information with the following:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

INSURANCE PATIENTS

_____ I understand that Baker & Graham Dental is an Out of Network Provider with my insurance company.

_____ I have presented my insurance benefit card to the receptionist.

_____ I agree to pay the estimated amount not covered by my insurance company at the time of my service. I understand that this is an insurance estimate and it is not a guarantee that my insurance will pay exactly as estimated. My insurance company and my plan benefits ultimately determine the amount paid. I understand that I am responsible for any remaining balance within 30 days after my insurance company pays my claim.

_____ I understand that all charges incurred are my responsibility regardless of my insurance coverage. I understand that you are my dental care provider and your relationship is with me and not my insurance company. My insurance policy is a contract between me, my employer, and my insurance company. Your office is not a party to that contract.

_____ By signing this form I instruct my insurance company to pay directly to your office.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS

_____ _____

PATIENT SIGNATURE OR PARENT OF CHILD Date