MIRAMAR BEACH DENTAL & ORTHODONTICS

Welcome! Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions, we'll be glad to help. (Please print)

Todays Date_____

Name _____[ ]Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____

Address _____ Occupation _____[ ] Male [ ] Female
City _____State_____Zip _____ Hm#(___)_____

Employer _____ Wk# (___)_____Ext_____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell# (___)_____

DOB ____/____/_____ SSN# _____-____-_____ E-mail _____@ _____._____

Spouses Name _____ Cell# (_____)_____

Spouses Occupation _____Wk# (_____)_____

Is patient a full time student? [ ] No [ ] Yes – If yes, Name of School _____

Responsible Party (if different than patient)

Name _____
Address _____
City _____State_____Zip _____
Hm#_____
Wk#_____
DOB ____/____/_____ SSN# _____-____-_____
E-mail _____@ _____._____
Relationship _____

YOUR PREFERENCES:
Do you prefer your appointment reminders by:
[ ] E-mail [ ] Phone [ ] Text
Do you prefer to receive call from our office at:
[ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you?
_____
How do you wish to be addressed by our staff?
_____

Insurance Information

Medical Insurance

Subscribers Name _____Relationship to patient _____
Subscribers DOB ____/____/_____ Subscribers SSN# _____-____-_____
Insurance Company _____ Policy #_____Group # _____
Insurance Company Telephone# _____
Subscribers Employer _____

Dental Insurance

Subscribers Name _____Relationship to patient _____
Subscribers DOB ____/____/_____ Subscribers SSN# _____-____-_____
Insurance Company _____ Policy #_____Group # _____
Insurance Company Telephone# _____
Subscribers Employer _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE: [ ] YES [ ] NO IF YES – PLEASE COMPLETE THE FOLLOWING

Subscribers Name _____Relationship to patient _____
Subscribers DOB ____/____/_____ Subscribers SSN# _____-____-_____
Insurance Company _____ Policy #_____Group # _____
Insurance Company Telephone# _____
Subscribers Employer _____

CONFIDENTIAL

MIRAMAR BEACH DENTAL & ORTHODONTICS

MEDICAL HISTORY and CONSENT

PLEASE MARK YES OR NO TO ALL

Patient Name: Date:

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

Allergies

Acrylics	Y	N
Anaphylaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Disease	Y	N
Chest Pain/Angina	Y	N
Congestive Heart	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid Problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Ears Ringing	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney Disease	Y	N
Nocturia	Y	N

General

Current Weight: _____lbs

Height: _____ft _____ins.

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/Hip replacement	Y	N
Liver Problems	Y	N
Recent trauma/Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

Hematological

Bleeding Problems	Y	N
Hepatitis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw Problems (TMD)	Y	N
Clicking	Y	N
Pain	Y	N
Difficulty Swallowing	Y	N
Difficulty chewing	Y	N
Orthodontics	Y	N
Periodontal Disease	Y	N
Teeth Clenching	Y	N
Teeth Grinding	Y	N
Tooth Pain	Y	N
Wisdom teeth extract	Y	N

Do you wear removable teeth? Y N

Do you take or need antibiotics before dental procedures? Y N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N
Osteoporosis	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness/Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis(MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorders	Y	N
Excessive Stress	Y	N
Memory Problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea (shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N

How often? _____

Has anyone told you that you snore? Y N

Social History

Do you smoke? Y N

Packs per day _____

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages? Y N

_____Drinks per day/week/month

Do you use recreational drugs? Y N

Thank you for your time in completing these forms. This information will assist our staff in providing optimal care.

MIRAMAR BEACH DENTAL & ORTHODONTICS

MEDICAL HISTORY and CONSENT

PLEASE MARK YES OR NO TO ALL

Patient Name: Date:

List any medications that you are taking: List any surgeries or hospitalizations you have had:

Medication	Dosage/Freq	Dr	Reason	Date	Surgery	Surgeon	Reason

Are you currently taking Bisphosphonates or other medication for osteoporosis? Y N

List and detail any medical condition or history not listed above:

Primary Physician's Name: _____ Physician's Phone: _____

Are you currently under the care of a physician? Y N If yes, please list:

Physician	Phone	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned herby authorizes Jason E Baker, DDS and his associates to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Jason E Baker, DDS and his associates to perform any and all forms of treatment deemed necessary. I understand that the use of local anesthetic agents embodies certain risk and consent to their use as deemed appropriate. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent (s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 ½% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Jason E Baker, DDS and his associates and staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult): **Date:** _____

Name of Patient: _____ **Signature:** _____

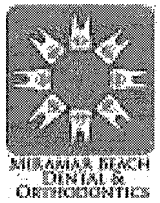
Consent (for minor child): **Date:** _____

Name of Parent/Guardian: _____ **Signature:** _____

Notice of Privacy Practices – Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging that our notice of our practices' policies and your rights regarding PHI have been made available to you. I allow release of pertinent medical records to my insurance company (if any) and my other medical providers.

Signature of Patient/Guardian: Date:

Doctor Signature: Date:



Cancellation and Broken Appointment Policy

Patient Name:_____ **Date:** _____

CANCELLATIONS: We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us a minimum of 24 business hours notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

POLICY AND FEES:

- Cancellation or rescheduling of an appointment with 24 business hours or more notification – no charge
- Cancellation or rescheduling of an appointment less than 24 business hours will be considered a broken appointment, consideration will be taken for emergencies and a charge will be made or not made at our discretion.
- Failure to give 24 hour advance notice:
    - We allow for one (1) broken appointment within a 12 month period
    - Any additional broken appointments within a 12 month period will be charged a fee
        - $75 for a hygiene appointment
        - $150 per hour for a doctor's appointment

DEPOSIT REQUIREMENT AFTER A BROKEN APPOINTMENT:

- A deposit may be required for appointments after a broken appointment. This deposit will be applied towards treatment cost once the appointment has been completed.

DEFINITION OF A "BROKEN APPOINTMENT":

A broken appointment is when you

- Cancel or reschedule an appointment with less than 24 business hours' notice.
- Do not show up for the scheduled appointment.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only.
When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

I have read and understand the above mentioned policy.

Patient signature (Parent or Guardian if minor) Date