BAIRD FAMILY DENTISTRY

NEW PATIENT QUESTIONAIRE

LEGAL NAME_____NICKNAME_____
ADDRESS_____CITY_____STATE____ ZIP_____
__BIRTHDATE_____
HOME#_____WORK#_____CELL#_____SS#_____
E-MAIL_____DO YOU TEXT_____

RESPONSIBLE PARTY_____ADDRESS_____
CITY_____STATE_____ZIP_____TELEPHONE#_____

PRIMARY INSURANCE

EMPLOYER_____
INSURANCE COMPANY_____
SUBSCRIBER_____DOB_____SS/ID#_____

SECONDARY INSURANCE

EMPLOYER_____
INSURANCE COMPANY_____
SUBSCRIBER_____DOB_____SS/ID#_____

EMERGENCY CONTACT_____
RELATION_____TELEPHONE_____

PATIENT
SIGNATURE_____DATE_____

PRINT NAME_____

As a courtesy we will gladly file your insurance claims. You will be responsible for your deductible, co-pay, and any balance left after insurance pays. You are also responsible for all charges not covered by your insurance plan. If your plan pays the member not the provider you will be responsible for 100% of charges at time of service. We do our best to estimate your co-pay but, it is only an estimate.

BAIRD FAMILY DENTISTRY

HEALTH HISTORY

NAME_____DOB_____

ARE YOU UNDER A PHYSICIAN'S CARE? IF YES, WHO_____ __Y__N

ALLERGIES:

PENICILLIN __Y__N, CODEINE __Y__N, ANESTHETICS __Y__N, ASPIRIN __Y__N, TYLENOL __Y__N, ACRYLIC __Y__N, LATEX __Y__N, METALS __Y__N, OTHER MEDICATIONS (list)_____

_____

_____

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN ANY BISPHOSPHONATES (ex. Fosamax, Boniva, Actonel, Aredia, Bondronat, OR Zometa) __Y__N

DO YOU HAVE A HISTORY OF CARDIOVASCULAR PROBLEMS, HEART ATTACK, PACEMAKER, OR ARTIFICIAL HEART VALVES (list_____) __Y__N

DO YOU TAKE BLOOD THINNERS (which one_____) __Y__N

DO YOU HAVE HIGH BLOOD PRESSURE (treated __Y__N) __Y__N

HAVE YOU BEEN DIAGNOSED WITH HEPATITIS __A__B__C (check type) __Y__N

HAVE YOU BEEN DIAGNOSED WITH HIV __Y__N

HAVE YOU BEEN DIAGNOSED WITH HUMAN PAPILLOMA VIRUS (HPV) __Y__N

ARE YOU DIABETIC __Y__N

DO YOU CURRENTLY HAVE OR EVER BEEN DIAGNOSED WITH MRSA (staph) __Y__N

DO YOU HAVE ASTHMA (last attack_____) (have an inhaler __Y__N) __Y__N

HAVE YOU EVER HAD SEIZURES OR CONVULSIONS (last episode _____) __Y__N

HEALTH HISTORY CONTINUED

NAME_____

DO YOU HAVE A HISTORY OF CANCER (type_____) __Y__N

FAMILY HISTORY OF ORAL CANCER __Y__N

HAVE YOU OR DO YOU CURRENTLY USE TOBACCO PRODUCTS __Y__N

HAVE YOU HAD A JOINT REPLACEMENT (when_____) __Y__N

WOMEN – ARE YOU PREGNANT (month_____) __Y__N

PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING:

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PATIENT SIGNATURE_____DATE_____

NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act (HIPPA), this notice is to inform you of our privacy practices, how protected health information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

AS A PATIENT YOU HAVE THE FOLLOWING RIGHTS:

1. **The right to inspect, copy, and correct you information.**
2. **The right to request your information and communications be restricted.**
3. **The right to a report of disclosures of your information or treatment.**
4. **The right to a copy of this notice.**

If you have questions regarding this notice, a request for information, copies of compliance statutes, or information to file a complaint concerning possible violations of HIPPA, please contact our office by mail or telephone.

Please list below all persons with whom we may discuss your information and dental treatment.

_____

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_____

We want to assure you that your medical and dental protected health information is secure with Baird Family Dentistry.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have read this notice.

_____ _____

Signature **Date**