WELCOME

PATIENT INFORMATION:

Date:_____

Name:_____
Birth Date:_____Male:___Female:___

Mailing Address:_____

_____
Home#:_____Cell#:_____
Work#:_____ Preferred#: H W C
Email:_____
Emergency Contact:_____
Phone#:_____
Relationship to patient:_____

Who may we thank for referring you to our office?

_____

RESPONSIBLE PARTY:
(If someone other than the patient)

Name:_____
Birth Date:_____
Address:_____

_____
Home#:_____Cell#:_____
Relationship to patient:_____

INSURANCE INFORMATION:

Primary Insurance:

Insurance Company:_____
Address:_____
Phone#:_____

Employee:_____
SSN or ID#:_____
Birth Date:_____
Relationship to patient:_____
Employer:_____
Group Number:_____

Secondary Insurance:

Insurance Company:_____
Address:_____
Phone#:_____

Employee:_____
SSN or ID#:_____
Birth Date:_____
Relationship to patient:_____
Employer:_____
Group Number:_____

OFFICE APPOINTMENT AND PAYMENT POLICY:

I understand that any cancellations must be at least 24 hours prior to the time reserved for appointments. Failure to cancel with 24 hours notice or missed no show appointments may result in a charge (per half-hour of time reserved).

I understand that I am financially responsible for all charges provided which are due at the time of service unless prior financial arrangements have been made. If you have insurance, as a courtesy we will file insurance claims for you. The estimated portion not covered by your insurance carrier is due at the time of service. Please realize insurance is estimated. Once insurance has paid any remaining balance must be paid by patient. Insurance companies frequently reimburse at lower rate than we estimate. When this occurs, you may be required to pay an additional "after insurance" balance. YOU ARE ULTIMATELY RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS.I further understand that any balance over 90 days will be subject to a $25 late fee per month late and if your account is sent to collections a finance charge of 18%.

I authorize payment of dental benefits to Baldwin Distinctive Dentistry. I authorize disclosure of my health information for the processing of dental claims.

Signature:_____ Date:_____

Medical History

Physician's Name:_____ Phone#:_____ **Circle one**

Have you been hospitalized recently? Yes No

Please list:_____

Are you taking any prescription medications (Including over the counter, herbal, or **Blood Thinners**)? Yes No

Please list:_____

Do you have any ALLERGIES to medication or substances? Yes No

Please list:_____

Do you require antibiotic premedication for dental procedures? Yes No

Indicate which of the following you have had in the past or currently have, Circle Yes or No to each item:

Heart (Disease, Attach, Surgery)	Yes	No	Glaucoma	Yes	No	Hepatitis (A,B,C)	Yes	No
Congenital Heart Condition	Yes	No	Kidney Problems	Yes	No	Diabetes	Yes	No
Artificial Heart Valve	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Artificial Joints	Yes	No	Cancer or Tumor	Yes	No	Asthma	Yes	No
Heart Murmer	Yes	No	Chemotherapy	Yes	No	Hay Fever	Yes	No
Heart Pacemaker	Yes	No	Radiation Therapy	Yes	No	Sinus Problems	Yes	No
Mitral Valve Prolapse	Yes	No	Thyroid Condition	Yes	No	Emphysema	Yes	No
Rheumatic Fever	Yes	No	Arthritis	Yes	No	Anxiety	Yes	No
Anemia	Yes	No	Epilepsy or Seizures	Yes	No	Psychiatric Treatment	Yes	No
Bleeding Disorder	Yes	No	Fainting or Dizziness	Yes	No	Weight Changes	Yes	No
Drug Addiction/Alcoholism	Yes	No	Blood Transfusions	Yes	No	Osteoporosis	Yes	No
Current Tobacco Use	Yes	No	HIV or Aids	Yes	No	Stroke	Yes	No
Fever Blisters/Herpes	Yes	No	Autoimmune Disease	Yes	No	High/Low Blood Pressure	Yes	No
Ulcers/Colitis/GERDS	Yes	No	Multiple Sclerosis	Yes	No			

BP Reading: ____/____

Do you have or have had any condition or disease not listed above? Yes No

If yes, please explain:_____

Have you ever had an adverse reaction to dental anesthetic or topical gels? Yes No

How often do you brush?_____ Floss?_____Do you use other dental aides?_____

Are your gums or teeth sensitive? Yes No

Do your gums bleed? Yes No

Do you clench or grind your teeth? Yes No

Do you have TMJ joint pain? Yes No

Do you wear a bite guard? Yes No

FOR WOMEN ONLY

Pregnant Yes No

Nursing Yes No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency. I will notify the dentist of any health or medication changes in the future. I authorize radiographs, study models, and any other diagnostic aides deemed appropriate to make a thorough dental diagnosis. I authorize treatment, medication, and therapy that may be indicated or necessary.

_____

Print Name

_____ _____

Signature: (Patient signature or parent signature if minor) Date

BALDWIN
Distinctive Dentistry

Dental Health Questionnaire

What are some things we can do to make your dental visits as comfortable as possible?_____

_____

APPEARANCE:

If you could change your smile would you:

-Make it Brighter/Whiter?.....Yes No
-Make it Straighter?.....Yes No
-Close Spaces?.....Yes No
-Repair Chipped Teeth?.....Yes No
-Replace Missing Teeth?.....Yes No
-Have a Smile Makeover?.....Yes No
-Replace Black Mercury Fillings?.....Yes No
-Replace Old Crowns that don't match?.....Yes No

DENTURES:

Do you wear partial or full dentures?.....Yes No

Would you be interested in replacing your loose dentures with fixed teeth or having your existing dentures relined?.....Yes No

Any concerns/questions for us?_____

_____