BAKER & OCHS, P.C.

Patient History

Patient Information

Today's Date_____

Name_____Birthdate_____Cell Phone_____

Address_____City_____State____Zip_____Phone(___)_____

Single__Married__Divorced__Widowed__ Male__Female__ SocSec#_____

Patient E-mail Address: _____

Patients Employer_____ Work Phone(___)_____

Address_____ City_____ St_____ Zip_____

Emergency Contact Person_____ Phone(___)_____

Whom may we thank for referring you?_____

Responsible Party

Name_____Relationship to Patient_____

Address_____City_____State_____Zip_____Phone(___)_____

Driver's Licence#_____Birthdate_____Soc Sec#_____

Employer_____Address_____City_____St____Zip_____

Work Phone(___)_____ Have you been a patient in our office? Yes___ No___

Insurance Information

Name of Insured_____Relationship to Patient_____

Address_____ City_____State____Zip_____Phone(___)_____

Birthdate_____ Soc Sec#_____ Date Employed_____

Employer_____ Phone(____)_____

Address_____City_____State_____ Zip_____

Name of Insurance_____Group #_____Phone (____)_____

Additional Insurance

Name of Insured_____Relationship to Patient_____

Address_____City_____State_____Zip_____Phone(___)_____

Birthdate_____ Soc Sec#_____ Date Employed_____

Employer_____ Date Employed_____

Address_____ City_____State_____ Zip_____

Name of Insurance_____Group #_____Phone(___)_____

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

INSURANCE: We understand the value of insurance benefits and will assist you in obtaining your maximum benefit. We will gladly process your claim for you and will also estimate your deductible and the portion that isn't covered by insurance. That amount is due at the time of treatment and may be paid by any of the options listed below. Our estimates are subject to final approval by your insurance company and could therefore change the amount due to our office.

PAYMENT OPTIONS:

1. **CASH:** This option includes money orders and personal checks.
2. **CREDIT CARDS:** We accept VISA, MASTER CARD and DISCOVER as payment for dentistry as your limit allows.
3. **CARE CREDIT:** Dental credit card or loan. Apply today: (Link to CareCredit application)

CHECKS RETURNED FOR INSUFFICIENT FUNDS WILL BE SUBJECT TO A $25.00 SERVICE CHARGE.

MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

_____ _____

Signature of patient

PATIENT MEDICAL HISTORY

Patient Name_____ Today's Date_____

Physician_____Office Phone (_____)_____

Address_____Date of Last Exam_____

Have you had any serious illnesses or operations? If yes, list date and describe:

_____

Have you ever taken weight loss medication? If yes, list the medication:

_____

(Women) are you pregnant?_____ Nursing?_____ Taking birth control pills?_____

Please check if you have or have had the following:

___AIDS/HIV infection	___emphysema	___leukemia
___anemia	___epilepsy/convulsions	___liver disease
___angina	___fainting/seizures	___mitral valve prolapse
___arthritis	___frequently tired	___radiation therapy
___asthma	___glaucoma	___respiratory problems
___blood pressure-high	___hay fever/allergies	___rheumatic fever
___blood pressure-low	___heart attack	___sexually transmitted disease
___blood transfusion	___heart disease	___stomach trouble/ulcer
___cancer	___heart murmur	___stroke
___cardiac pacemaker	___heart trouble	___swollen ankles
___chest pains	___hepatitis/jaundice	___thyroid problem
___controlled substances used	___joint replacement/implant	___tobacco habit
___diabetes	___kidney disease	___tuberculosis
___easily winded	___latex allergy	___weight loss

___other:_____

Please expand on any of the above conditions_____

_____

Medications: List all medications currently taking_____

_____

Allergies: List all allergies_____

_____

PATIENT DENTAL HISTORY

Reason for today's visit_____

Date of last dental visit_____Date of last full mouth x-rays_____

Check if you have had any of the following:

___bad breath/bad taste in mouth ___head/neck/jaw injuries ___sensitivity to sweet/sour

___bleeding gums ___loose teeth or broken fillings___sensitivity when biting

___clicking or popping jaw ___orthodontic treatment ___sores/growths in mouth

___food collection between the teeth ___periodontal treatment ___wear dentures/partials

___grinding teeth ___sensitivity to hot/cold date of placement____

___bite lips/cheek ___had difficult extractions ___headaches

___prolonged bleeding following extractions

___received oral hygiene instructions regarding the care of your teeth and gums

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 records of any treatment or examination rendered to me or my child during the period of such dental care, to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

X_____ _____

Signature of patient (or parent if minor) Date

Payment is due in full at time of treatment unless prior arrangements have been approved.