Welcome to Baker Family Dentistry!

Name: ____
Last First MI

Preferred Name: ________________________ ❑ Male ❑ Female

Address: __________________________ City ____________ State ____ ZIP______

SSN:_______________________ DOB:____________________

Home Phone:__________________ Work Phone:___________________

Cell Phone:____________________ E-mail Address: _______________________

Employer:_____________________ Occupation:___________________________

Marital Status: (circle one) Single Married Divorced Widowed Separated Domestic Partner

How did you hear about our office?____

May we send appointment reminders via text message? ❑ Yes ❑ No

Insurance – Primary — Subscriber Information

Subscriber Name: ______________________ Relationship to Patient: _____________

DOB: ___/___/____ SSN/ID: ____-___-_____ Employer: _________________________

Insurance Company Name:____

Insurance Company Address:____

Insurance Company Phone: __________________ Group Number: ________________

Insurance – Secondary — Subscriber Information

Subscriber Name: ______________________ Relationship to Patient: _____________

DOB: ___/___/____ SSN/ID: ____-___-_____ Employer: _________________________

Insurance Company Name:____

Insurance Company Address:____

Insurance Company Phone: __________________ Group Number: ________________

*Assignment and Release *

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Baker Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship: __________________ Date: _______________________

* Consent *

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:____

Medical History

Do you have a personal physician? ❑ Yes ❑ No
Physician's Name:________________________ Physician's Phone: _________________
Date of last visit: _________________ Are you currently under treatment? ❑ Yes ❑ No
Please explain: ____
Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Do you use tobacco in any form? ❑ Yes ❑ No Frequency? ________________________
Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No If so, when? _____
Are you taking any medications? ❑ Yes ❑ No
Please list each one:____
Have you ever had any surgical procedures? ❑ Yes ❑ No
Please list each one: ____

Conditions — Please mark each one

Yes No
❑ ❑ Abnormal Bleeding
❑ ❑ Alcohol Abuse
❑ ❑ Allergies
❑ ❑ Anemia
❑ ❑ Angina Pectoris
❑ ❑ Arthritis
❑ ❑ Artificial Heart Valve
❑ ❑ Asthma
❑ ❑ Blood transfusion
❑ ❑ Cancer
❑ ❑ Chemotherapy
❑ ❑ Colitis
❑ ❑ Congenital Heart Defect
❑ ❑ Diabetes
❑ ❑ Difficulty Breathing
❑ ❑ Drug Abuse
❑ ❑ Emphysema

Yes No
❑ ❑ Epilepsy
❑ ❑ Facial Surgery
❑ ❑ Fainting Spells
❑ ❑ Fever Blisters
❑ ❑ Frequent Headaches
❑ ❑ Glaucoma
❑ ❑ HIV + AIDS
❑ ❑ Heart Attack
❑ ❑ Heart Murmur
❑ ❑ Heart Surgery
❑ ❑ Hemophilia
❑ ❑ Hepatitis A
❑ ❑ Hepatitis B
❑ ❑ Hepatitis C
❑ ❑ High Blood Pressure
❑ ❑ Joint Replacement
❑ ❑ Kidney Problems
❑ ❑ Liver Disease

Yes No
❑ ❑ Low Blood Pressure
❑ ❑ Mental Disorders
❑ ❑ Mitral Valve Prolapse
❑ ❑ Pacemaker
❑ ❑ Psychiatric Problems
❑ ❑ Radiation Therapy
❑ ❑ Rheumatic Fever
❑ ❑ Seizures
❑ ❑ Sexually Transmitted Disease
❑ ❑ Shingles
❑ ❑ Sickle Cell Disease
❑ ❑ Sinus Problems
❑ ❑ Stroke
❑ ❑ Thyroid Problems
❑ ❑ Tuberculosis
❑ ❑ Ulcers

Any other conditions we should be aware of:___________________________________
Any Allergies: ❑ Aspirin ❑ Codeine ❑ Dental Anesthetics ❑ Erythromycin ❑ Jewelry
❑ Latex ❑ Metals ❑ Penicillin ❑ Sulfa ❑ Tetracycline ❑ Other: _________________
Females: Pregnant ❑ Yes ❑ No If so, how many weeks? _______ Nursing? ❑ Yes ❑ No

Emergency Contact Name: ___________________________ Relationship: ____________
Address:____Phone:_____________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:____

Date:_______________________________

Dental History

How may we help you today? ____

Are you currently in pain? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No ❑ Unsure

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (new job, moving, relationships, etc.) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed when you brush or floss? ❑ Yes ❑ No

How many times do you: floss/week?____________ brush/day?____________

Are your teeth sensitive to heat, cold, sweets, or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning?____

When was your last dental visit? ____

What was the reason for your last dental visit? __________________________________

Why did you leave your previous dentist? ______________________________________

Is there anything we can do to better accommodate you during your dental visit?

____

At Baker Family Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers	Night Guards
Braces	Smile Makeover	Sports Guards
Sealants	Crowns	Bonding
Partials	Bridges	Implants
Dentures		