PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Ever taken fen-phen?* _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur *	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart Attack/Failure *	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint *	☐	☐	Nervousness	☐	☐
Heart Pace Maker *	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	Genital Herpes	☐	☐	Allergies (Pollen / Dust)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Bloody Sputum	☐	☐	Night Sweats	☐	☐						

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____

C-113L STEPPING STONES TO SUCCESS™ 1-800-548-2164
P.O. Box 11013, Pueblo, CO 81001

DENTAL AND MEDICAL HISTORIES - UPDATES

I. PATIENT INFORMATION & RESPONSIBLE PARTY DATE:_____

PATIENT INFORMATION:

PATIENT NAME_____ **Please Circle: MINOR SINGLE MARRIED MALE FEMALE**

BIRTHDATE_____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME_____ GRADE_____

PERSON RESPONSIBLE FOR ACCOUNT: **Please Circle: PATIENT GUARDIAN SPOUSE FATHER MOTHER**

LAST FIRST MIDDLE

STREET CITY STATE ZIP

HOME PHONE NUMBER_____ WORK PHONE NUMBER_____

SOCIAL SECURITY NUMBER_____ STATE DRIVERS LICENSE_____

DENTAL INSURANCE COMPANY SUBSCRIBER NUMBER GROUP#

EMPLOYER NAME & PHONE NUMBER INSURED BIRTHDATE (MO/DAY/YR)

III. PERSON TO CONTACT IN CASE OF EMERGENCY: OUTSIDE OF IMMEDIATE FAMILY.

NAME _____ TELEPHONE _____

ADDRESS_____

V. MINOR CONSENT

I give Bahia Dental Group, and the attending Dentist permission to provide dental treatment to my son/daughter.
I understand changes in treatment plan may occur and I authorize necessary dental treatment.
I certify that I am the guardian of the child and have legal custody.
Parent/Guardian_____

VI. ASSIGNMENT OF INSURANCE BENEFITS

I here by authorize payment directly to the Bahia Dental the group insurance benefits other wise payable to me. I understand that I am responsible for all costs of dental treatment.
I grant the right to Bahia Dental Group to release my dental/medical histories and other information to third party payors and/or other health professionals as necessary.

Signature: _____

VII. DENTAL MATERIAL FACT SHEET

I_____ acknowledge that I have had the opportunity to review/read or have received a copy of the Dental Materials Fact Sheet dated 10.17.01

Signature:_____ Date _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

DENTAL TREATMENT CONSENT FORM

Please read and sign the bottom of this form.

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (sever allergic reaction). Do not drive or operate heavy machinery while under the effects of dental narcotic analgesics.

USE OF DENTAL ANESTHETIC

I understand that the use of anesthetic can cause an increase in heart rate, feeling of faintness, drowsiness, and heart palpitations. I am also aware of the minimal risk for nerve injury that may cause numbness in my teeth, lips, tongue, and surrounding tissues that can last for an indefinite period of time.

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

DENTAL INSURANCE

Please understand that dental insurance is a contract between you, your insurance carrier, and your employer. We will help in every way we can in filing your claim, however, you are responsible for all dental fees in the event your insurance company denies coverage, eligibility, and/or payment. Please be aware that we are only able estimate your co-payment due to periodic changes within their contracts. You are responsible for insuring your eligibility with your dental insurance company each time dental service are provided.

ARBITRATION AGREEMENT

I understand that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be detemined by submission to arbitration as provided by California law.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient/Guardian_____ Date_____

Bahia Dental Group
Our Financial Policy

Thank you for choosing Bahia Dental Group as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign for treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT: CareCredit Payment Plan, Visa, M/C, American Express, Checks, and Cash

Regarding Insurance
We will accept assignment of insurance benefits, however, please understand that your dental insurance is a contract between you and your employer/insurance carrier. The account balance is your responsibility whether your insurance company reduces the estimate payment or denies your claim. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance plan.
Regarding Insurance Plans where we are a participating provider. All co-pays deductibles are due prior to or at time of treatment.

Usual and Customary Rates
Our practice is committed to provide the best treatment of our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients
Adult patients are responsible for full payments at time service.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service has been verified.

Missed appointments
Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit, **$25**. All Major Treatments, Saturday, and Holiday appointments failed without a 24 hour notices are charged **$50** per visit. Please help us serve you better by keeping scheduled appointments, or proving 48 hours notices.

Interest
We reserve the right to charge interest in the amount of 18% as provide by state law.

Collections
In case of default of payment, I promise to pay any legal interest on the balance due, together with any collections costs and reasonable attorney fees incurred to effect collection of this account or future.

Thank you for understanding our financial Policy. Please let us know if you have any questions or concerns.
I have read, and I understand and agree to the Financial Policy:

X_____ Date_____

Signature of Patient or Responsible Party

X_____ Date_____

Signature of Co-Responsible Party

BAHIA DENTAL GROUP

NOTICE OF PRIVACY PRACTICES

Please review carefully
New Federal laws written to protect the confidentially of your health information.

Protecting Your Confidential Health Information HIPAA—Health Insurance Portability and Accountability Act

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

We want you to be informed about the polices and procedures which have been developed to make sure your health information will not be shared with anyone who doesn't require it. Our office is subject to State and Federal laws regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights.

We will use and communicate your Health Information for the purpose of provide you treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purpose unless we have asked for and have been voluntarily given your written permission.

How your HEALTH INFORMATION may be used.

To provide treatment: We will use your health information within our office to proved you the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentist, clinical and dental laboratories, pharmacies, or other health care personnel that provide you treatment.

To obtain payment: We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To conduct Health care operations: Your health information may be used during staff trainings. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance review. Your health information may be reviewed during the routine processing of certification, licensing, credentialing activities.

In patient reminders: We will remind you of a scheduled appointment or that it is time for you to contact us and make and appointment by mail or phone calls. These may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders.).

Abuse or Neglect: We will notify government authorizes if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security: We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic the understanding of new side effect of a drug treatment or medical device.

For Law Enforcement: As permitted or required by State of Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime, or in order to report a crime.

Family, Friends and Caregivers: We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, and payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment with sharing your health information only when it will be important to those participating in providing your care.

Authorization to use or disclose health information: Other than is stated above or where Federal, State, Local Law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information.

Confidential Communication: You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communication that are sealed.

Inspect and copy your health information: You have the right to read, review and copy your health information including your complete chart, x-rays, and billing records. If you would like a copy of your health information please let us know in writing. We may charge a reasonable fee to duplicate and assemble your copy.

Amend your Health Information: You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. Please provide us with your request in writing and describe the reason for the change.

Documentation of Heath Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment payment or health operations. Our documentation procedures will enable us to prove information on health information usage for April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Please limit your request to no more that six years at time. We may need to charge you a reasonable fee for your request.

Request a paper copy of this notice: You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. We are required by law to maintain the privacy of your health information and to prove you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures describe in the notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure to provide you a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complains in writing.

PATIENT ACKNOWLDEGEMENT

Patient Name(s):

_____

_____

_____

Patient Signature:_____ Date:_____