Patient Information

Date _____

Full Name _____ Birth Date _____ Marital Status _____
Home Address _____ Zip _____ Home Phone _____
E-Mail _____ Cell Phone _____
Occupation _____ Employer _____ Social Security No. _____
Business Address _____ Zip _____ Work Phone _____
Name of Spouse _____ Occupation _____ Employer _____
Dental Insurance Company _____ Policy No. _____
Referred By _____ Previous Dentist _____
Name of Physician _____ Phone No. _____
In Case of Emergency Contact _____ Phone No. _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No
1. Have you ever been hospitalized, major operations or serious illness?	☐	☐
If so, what? _____		
2. Are you under any medical treatment now?	☐	☐
3. Have you ever taken Fen-Phen/Redux?	☐	☐
4. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin?	☐	☐
5. Has there been a change in your health in the past year?	☐	☐
6. Have you ever had a blood transfusion?	☐	☐
7. Have you ever had kidney dialysis treatment?	☐	☐
8. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	☐	☐
9. Are you now taking drugs or medications?		
If so, what? _____		

10. Has a physician ever informed you that you had:

	Yes	No		Yes	No
Heart Ailment	☐	☐	Hepatitis or Yellow Jaundice	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Venereal Disease	☐	☐
Heart Murmur	☐	☐	AIDS	☐	☐
Mitral Valve Prolapse	☐	☐	Stomach or Intestinal Disease	☐	☐
Angina	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Tumors or Growths	☐	☐
Blood Disease	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Respiratory Disease	☐	☐
			Epilepsy	☐	☐

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women: A. Are you pregnant?	☐	☐
B. Estimated Date of Delivery _____		

Signature _____ Date _____

Updating _____

_____

_____

_____

_____

Medical History Summary

Blood Pressure:

Dental History

	Yes	No
1. Please state briefly the reason for your visit. _____		
2. Do you have discomfort in your mouth now?	☐	☐
3. How long since your last dental visit? _____		
4. Were X-rays taken of all teeth at that time?	☐	☐
5. Do your gums bleed, feel tender or irritated?	☐	☐
6. Are your teeth sensitive to hot/cold/sweets?	☐	☐
7. Does food wedge between certain teeth?	☐	☐
8. Are any teeth loose?	☐	☐
9. Do you grind, clench or grit your teeth?	☐	☐
10. Does your jaw ever click or cause pain opening or closing?	☐	☐
11. Have your front teeth separated creating spaces in them recently?	☐	☐
12. Have you ever had any teeth extracted?	☐	☐
If yes, have they been replaced to prevent shifting and tipping of remaining teeth and bite collapse?	☐	☐
13. Did you ever wear braces?	☐	☐
14. Have you ever worn any dental appliances?	☐	☐
15. Have you ever had a root canal?	☐	☐
16. Have you ever had gum treatments?	☐	☐
17. Do you wear dentures or plates?	☐	☐
If yes, are you satisfied with your present dentures?	☐	☐
18. Have you experienced any growths or sore spots in your mouth?	☐	☐
19. Do you have an unpleasant taste in your mouth?	☐	☐
20. Do you floss your teeth?	☐	☐

21. Type of tooth brush _____ hard or soft (circle one)

Updating _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dental History Summary

All Smiles
FAMILY DENTAL
where healthy smiles begin

Debbie-Ann Bailey, D.M.D

Appointments in our office

Here at Dr. Bailey's office we strive to give our patients the best of care. We give appointments that work best with your schedule as well as ours. We understand that different situations can occur however, we ask our patients to please give us 48 hours notice if unable to keep their appointment. Any patient that has confirmed their appointment and "CANCEL" or "NO SHOW" on the appointment day will be charged a $50 fee. We appreciate your understanding as we reserve this time for you. _____
Initial

Financial Policy

In our office we work individually with each patient to suit their needs. We value our patients and our financial coordinator is able to inform you before any treatment is started what the cost will be. Our office does not send statements, and payment is due at the time of service. As a courtesy we will file your insurance. _____
Initial

If insurance does not pay in 90 days you are responsible for your balance. _____
Initial

Please Sign Below that you have read and understood this page:

_____ _____

All Smiles
FAMILY DENTAL
where healthy smiles begin

Debbie-Ann Bailey, D.M.D

CONSENT FOR TREATMENT

Patients Name:_____

Date:_____

I have discussed any concerns where I thought necessary, and I am satisfied that I have a full understanding of the proposed treatment and risk involved. I hereby authorize Debbie-Ann Bailey D.M.D and associates to perform the necessary treatment needed. Dr. Debbie-Ann Bailey D.M.D and associates explained to me fully the purpose of the treatment needed. I hereby give my permission for the use of dental records, including photographs taken in the process of examinations, treatments, and retention for the purpose of professional journals. I have also been explained the cost of treatment and the insurance estimated payment if any. *

Patient Signature: _____

Witness Signature: _____

Signature of guardian if patient is minor:_____

*If for any reason your insurance company does not pay the estimated amount, it becomes your obligation.

All Smiles
FAMILY DENTAL
where healthy smiles begin

Debbie-Ann Bailey, D.M.D

NEW PATIENT INFORMATION

Please take a moment to complete the following short questionnaire. Your answers help us learn a little about you and your preferences and assist us in coordinating our marketing efforts overall. We appreciate your feedback and look forward to serving your dental needs. Thank You!

Name:_____

Email address:_____

First Visit date:_____

City You live in:_____

How did you hear about our office?
Please circle one thank you!!

Friends
Postcard mailer
Flyer
Sign
Insurance
Other_____

_____

All Smiles
FAMILY DENTAL
where healthy smiles begin

Debbie-Ann Bailey, D.M.D

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____, have read and understood the office's Notice of Privacy Practices.

_____
(Please print Name)

_____
(Signature)

_____
(Date)

For Office use Only

We have attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

___ Individual refuse to sign

___ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

___ Other (please specify)

A copy will be available for you to read in our office.
You may also request a copy of this Notice of Privacy Practices at any time.