BABINER DENTAL
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New Patient Packet

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____ SSN: _____

Sex:
- ○ Male
- ○ Female

Address: _____ City: _____ State: _____ Zip: _____

Cell phone: _____ Home Phone: _____ Email: _____ EMERGENCY CONTACT PERSON: _____ EMERGENCY CONTACT PHONE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Friend, Family, Walk in, Internet, Insurance or Other) _____

Patient, Parent or Guardian: Sign

Date: _____

PLEASE MAKE SURE TO PROVIDE YOUR ID AND INSURANCE CARD TO THE FRONT DESK STAFF, THANK YOU.

MEDICAL HISTORY

Patient First Name: _____ Patient Last Name: _____ Birthdate: _____

Are you under medical treatment now?
- ○ Yes
- ○ No

If Yes, _____

Have you ever been hospitalized for any surgical operation or serious illness?
- ○ Yes
- ○ No

If Yes, _____

Do you use alcohol?
- ○ Yes
- ○ No

If Yes, _____

Do you use tobacco?
- ○ Yes
- ○ No

If Yes, _____

Do you use recreational drugs?
- ○ Yes
- ○ No

If Yes, _____

Are you taking any medication(s) including non-prescription medicine?
- ○ Yes
- ○ No

If YES, please list the medication(s) you are _____

Allergies?
- ☐ Allergic to Aspirin
- ☐ Allergic to Latex
- ☐ Allergic to Local Anesthetics
- ☐ Allergic to Metal
- ☐ Allergic to Sulfa Drugs
- ☐ Barbituates
- ☐ Local Anesthetics (eg. novacaine)
- ☐ Other Allergy
- ☐ Penicillin or other antibiotics
- ☐ Sedatives

Other Allergy (please specify) _____

Do you have persistent cough or throat clearing not associated with a known illness (lasting more than 3)
- ○ Yes
- ○ No

WOMEN ONLY:

	Yes	No
- Are you pregnant or think you may be	○	○
- Are you nursing?	○	○
- Are you taking birth control pi lls?	○	○

Problems

- ☐ AIDS/HIV Positive
- ☐ Anxiety
- ☐ Aspergers or ASD
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Brain stent
- ☐ Brain stents/Coils
- ☐ brainstents/coils
- ☐ Cancer
- ☐ Chest Pains
- ☐ Convulsions
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells/Dizziness
- ☐ Frequently Tired
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ HighBloodPressure
- ☐ Joint replacement
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ MitralValveProlapse
- ☐ Organ transplant
- ☐ Pacemaker
- ☐ Parathyroid Disease
- ☐ Psychiatric Disorder
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ seasonal allergies
- ☐ Sexually Transmitted Disease
- ☐ Stens in Heart
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Valve Replacement
- ☐ Zenker's Diverticulum

- ☐ Angina
- ☐ Cardiac Pacemaker
- ☐ Renal Failure
- ☐ Heart Disease
- ☐ Sickle Cell Anemia
- ☐ Thyroid Problem
- ☐ Stomach Troubles / Ulcers
- ☐ Implant
- ☐ 22q11.2 Deletion Syndrome
- ☐ Other

Other?

- ○ Yes
- ○ No

.

DENTAL HISTORY

	Yes	No
Do your gums bleed while bru shing or flossing?	○	○
Are your teeth sensitive to hot or cold liquids/foods?	○	○
Are your teeth sensitive to sw eet or sour liquids/foods?	○	○
Do you feel pain to any of your teeth?	○	○
Do you have any sores or lum ps in or near your mouth ?	○	○
Do you clench or grind your te eth?	○	○
Have vou had any head. neck or jaw injuries?	○	○
Have you had any orthodontic treatment?	○	○
Have vou ever had prolonged bleeding following extraction s?	○	○

Have you ever experienced any of the following problems in your jaws ?

	Yes	No
- Clicking?	○	○
- Pain (joint. ear. side or face)?	○	○
- Difficulty in opening or closin g ?	○	○
- Difficulty in chewing?	○	○

Is there anything else we should know regarding your health or this visit? Please state below:

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- ☐ I certify that | have read and understand the above information. To the best of my knowledge. the above questions have been accurately answered.

Patient, Parent or Guardian:

Sign

Date:

ACKNOWELEDGEMENT OF NOTICE OF PRIVACY ACT OF PRACTICES

Babiner Dental Medicine Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we will provide you, copies of the current notice may be obtained from our office.

PAYMENT POLICY

We make every effort to minimize the cost of your care. You may request an estimate of the charges for any procedure prior to the start of work. We feel everyone benefits when there is a definite and clear financial agreement prior to treatment. To make your financial arrangement as easy as possible, we accept Cash, Money Order, Visa, MasterCard, and American Express (as well as CareCredit and Well Fargo Financing). Payment in full is due the day of treatment. Some procedure charges may be made in several installments, depending on the length of treatment, but must be paid in full upon procedure completion. You agree that, in case you are using the coverage of your dental insurance, this coverage is not a guarantee of payment (as Dental Insurances establish) and, YOU ARE RESPONSIBLE for all portions that your insurance does not pay to

Babiner dental. Your deductible and co-pay, if any, will be due and collected at the time of service! No payment arrangement may be used with this option. We will be happy to help explain your insurance benefits to you, but it is ultimately the patient's responsibility to know their insurance benefits and to make sure that their claims are paid in a timely manner. Your insurance is a contract between you, your employer, and the insurance company. You understand that for any treatment payment in full is due at the time of service. Completed procedures are none refundable.

APPOINTMENT CANCELLATION POLICY

It is your responsibility to keep your appointment. If you are unable to keep an appointment, kindly give us at least 24 hours notice. Any appointment that is failed or canceled with less than 24 hours notice will result in $50 APPOINTMENT CANCELLATION FEE. This charge must be paid before another appointment will be scheduled. Unless it is an emergency as determined by the attending doctor, Babiner Dental may refuse services if: 1. YOU DID NOT CONFIRM YOUR APPOINTMENT WITHIN 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TIME 2. YOU HAVE NOT MET ANY UNPAID BALANCE 3. YOU HAVE CANCELLED 5 (FIVE) TIMES DURING A CALENDAR YEAR (BY CALLING 24 HOURS IN ADVANCE OF YOUR APPOINTMENT) 4. YOU HAVE 2 (TWO) OR MORE BROKEN APPOINTMENTS DURING A CALENDAR YEAR (BY NOT CALLING TO CANCEL YOUR APPOINTMENT AT LEAST 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TIME) We reserve the right to reschedule or refuse to schedule any appointments in the future if any of these cases apply to you. We also reserve the right to reschedule your appointment if your doctor is sick or in any case of similar emergency situation.

REFUND POLICY

You may cancel a course of treatment for which you have booked an appointment and be fully refunded all fees for treatment NOT YET PERFORMED; provided you give Babiner dental a minimum of 24 hours prior notice. If 24 hours prior notice is not received, Babiner dental reserves the right to withhold a proportionate amount of money, based upon the length of the appointment, to cover overheads.

BY SIGNING BELOW THIS FORM, I AM ACKNOWLEDGING THAT:

- ☐ I am either the patient or the patient's personal representative;
- ☐ I have received a copy of the "Notice of Privacy Practices" for Babiner dental; and
- ☐ I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature:

Sign

Date: