

# Baker & Graham

FAMILY DENTISTRY

## WELCOME TO THE OFFICE OF

*William C. Baker, Jr. D.D.S. P.A., Erik G. Graham D.M.D. P.A., Ethan E. Moore D.M.D.*

*Thank you for selecting our dental healthcare team! We strive to provide you with the best dental care possible. To help us meet all your dental healthcare needs, please complete this form in ink. If you have any questions or need assistance, please ask us ~ we will be happy to help.*

### PATIENT INFORMATION (CONFIDENTIAL)

Date \_\_\_\_\_

#### PATIENT:

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Preferred Name to be called (Nickname) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Mailing Address \_\_\_\_\_ Street Address \_\_\_\_\_

E-mail \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cellular Phone ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

How would you like to receive your statements  Mail  Email  Both

#### PATIENT'S SPOUSE:

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

#### EMERGENCY INFORMATION:

**Name of someone not living with you (in case of emergency).**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

**• PLEASE COMPLETE SECTION BELOW IF PATIENT IS MINOR OR STUDENT •**

#### PATIENT'S FATHER:

Father's Name \_\_\_\_\_ Father's Date of Birth \_\_\_\_\_

Father's Home Address \_\_\_\_\_

Father's Email \_\_\_\_\_

Father's Home Phone ( ) \_\_\_\_\_ Father's Work Phone ( ) \_\_\_\_\_ Father's Soc. Sec. # \_\_\_\_\_

Father's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Father's Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

#### PATIENT'S MOTHER:

Mother's Name \_\_\_\_\_ Mother's Date of Birth \_\_\_\_\_

Mother's Home Address \_\_\_\_\_

Mother's Email \_\_\_\_\_

Mother's Home Phone ( ) \_\_\_\_\_ Mother's Work Phone ( ) \_\_\_\_\_ Mother's Soc. Sec. # \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

#### INSURANCE INFORMATION:

Do you have dental insurance?  yes  no

**If yes, please provide us with your dental insurance card.**

**PATIENT DENTAL HISTORY:**

Name of previous dentist \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone Number \_\_\_\_\_

1. Please check any of the following problems that apply to you.

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| Sensitivity/Pain (e.g. hot, cold, sweet, pressure) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Where? UR LR UL LL                                       |                          |                          |
| Headaches, earaches, neck pain .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaw joint pain.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Teeth or fillings breaking.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Grinding or clenching teeth.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding, swollen or irritated gums .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening/closing .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Loose, tipped or shifting teeth.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Bad breath .....   | <input type="checkbox"/> | <input type="checkbox"/> |

2. Do you have or have you had any of the following? ...

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Dentures .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Partial dentures.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Braces .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Periodontal (gum) treatments.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Any sores or lumps in or near your mouth .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Any difficult extractions in the past .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Any prolonged bleeding following extractions ..... | <input type="checkbox"/> | <input type="checkbox"/> |

3. Do you smoke, vape or use chewing tobacco?

How much? \_\_\_\_\_ How long? \_\_\_\_\_

4. Please share the following dates:

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-rays \_\_\_\_\_ / \_\_\_\_\_

5. If I could change my smile, I would:

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| Make it whiter .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Make it straighter .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Close spaces .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Make teeth longer .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Change the shape of the teeth .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace black metal fillings with tooth colored restorations .. | <input type="checkbox"/> | <input type="checkbox"/> |
| Repair chipped teeth .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace missing teeth .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace old crowns that don't match .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Have a smile makeover .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |

6. On a scale of 1-10, with 10 being the highest rating:

- How important is your dental health to you?  
 1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?  
 1 2 3 4 5 6 7 8 9 10
- Where do you want your dental health to be?  
 1 2 3 4 5 6 7 8 9 10

7. Why did you leave your previous dentist?  
 \_\_\_\_\_

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

What is the most important thing to you about your dental visit today? \_\_\_\_\_

**PATIENT MEDICAL HISTORY:**

Name of family physician \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone Number \_\_\_\_\_

1. Please check any of the following problems/conditions that apply to you:

- |                           |                          |                          |                            |                          |                          |                             |                          |                          |                      |                          |                          |
|---------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|
| AIDS                      | Yes                      | No                       | Diabetes                   | Yes                      | No                       | High blood pressure         | Yes                      | No                       | Respiratory problems | Yes                      | No                       |
| Allergies (seasonal)      | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                  | <input type="checkbox"/> | <input type="checkbox"/> | HIV positive                | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever      | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia                    | <input type="checkbox"/> | <input type="checkbox"/> | Drug addiction             | <input type="checkbox"/> | <input type="checkbox"/> | HPV (human papilloma virus) | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism           | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina (chest pain)       | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema                  | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                    | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever        | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis                 | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                   | <input type="checkbox"/> | <input type="checkbox"/> | Jaw joint pain              | <input type="checkbox"/> | <input type="checkbox"/> | Seizures             | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve    | <input type="checkbox"/> | <input type="checkbox"/> | Excessive bleeding         | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease              | <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems       | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joints         | <input type="checkbox"/> | <input type="checkbox"/> | Fainting                   | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease               | <input type="checkbox"/> | <input type="checkbox"/> | Sleep apnea          | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                    | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                   | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure          | <input type="checkbox"/> | <input type="checkbox"/> | Stomach problems     | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disease             | <input type="checkbox"/> | <input type="checkbox"/> | Heart conditions           | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse       | <input type="checkbox"/> | <input type="checkbox"/> | Stroke               | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding (currently) | <input type="checkbox"/> | <input type="checkbox"/> | Heart lesions (congenital) | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness/depression      | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease      | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise easily             | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur               | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis         | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer                    | <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery              | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker                   | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers               | <input type="checkbox"/> | <input type="checkbox"/> |
| Cervical cancer           | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A                | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant (currently)        | <input type="checkbox"/> | <input type="checkbox"/> | Veneral diseases     | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy              | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B                | <input type="checkbox"/> | <input type="checkbox"/> | Radiation (head/neck)       | <input type="checkbox"/> | <input type="checkbox"/> | Other _____          |                          |                          |
| Cortisone medication      | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C                | <input type="checkbox"/> | <input type="checkbox"/> | Reflux                      | <input type="checkbox"/> | <input type="checkbox"/> |                      |                          |                          |

2. Are you allergic or have you reacted adversely to any of the following medications?

- |             |                          |                          |                  |                          |                          |              |                          |                          |                                    |                          |                          |
|-------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| Aspirin     | Yes                      | No                       | Hydrocodone      | Yes                      | No                       | Penicillin   | Yes                      | No                       | Valium                             | Yes                      | No                       |
| Clindamycin | <input type="checkbox"/> | <input type="checkbox"/> | Latex            | <input type="checkbox"/> | <input type="checkbox"/> | Percodan     | <input type="checkbox"/> | <input type="checkbox"/> | Any metals (nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine     | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetic | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa        | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                        |                          |                          |
| Halcion     | <input type="checkbox"/> | <input type="checkbox"/> | Nitrous Oxide    | <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline | <input type="checkbox"/> | <input type="checkbox"/> |                                    |                          |                          |

3. Have you ever taken any of the following medications for osteoporosis?

- |         |                          |                          |                    |                          |                          |
|---------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|
| Actonel | Yes                      | No                       | Herbal Supplements | Yes                      | No                       |
| Aredia  | <input type="checkbox"/> | <input type="checkbox"/> | Reclast            | <input type="checkbox"/> | <input type="checkbox"/> |
| Boniva  | <input type="checkbox"/> | <input type="checkbox"/> | Zometa             | <input type="checkbox"/> | <input type="checkbox"/> |
| Fosamax | <input type="checkbox"/> | <input type="checkbox"/> | Other _____        |                          |                          |

Are you under a physician's care? What for?  
 \_\_\_\_\_

What medications are you currently taking?  
 \_\_\_\_\_

**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 the records of any treatment or examination rendered to me or my child during the period of such Dental care, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

\_\_\_\_\_  
 Patient Signature (parent if child)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness Signature

## Consent to Perform Dentistry

# Baker & Graham

FAMILY DENTISTRY

- 1** I hereby authorize and direct the dentist(s) of Baker & Graham and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
  - A** • Preventative hygiene treatment (prophylaxis) and the application of topical fluoride.
  - B** • Application of plastic “sealants” to the grooves of the teeth.
  - C** • Treatment of diseased or injured teeth with dental restorations (fillings or crowns).
  - D** • Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
  - E** • Removal (extraction) of one or more teeth.
  - F** • Treatment of diseases or injured oral tissues (hard and/or soft).
  - G** • Use of sedative drugs to control apprehension and/or disruptive behavior.
  - H** • Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
  - I** • Use of general anesthesia to accomplish the necessary treatment.
- 2** I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
- 3** I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves and indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the risks and complications.
- 4** I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and wellbeing in the professional judgement of the dentist.
- 5** There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respirator and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
- 6** I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
- 7** I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
- 8** I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
- 9** I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM File #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Witness

# Baker & Graham

FAMILY DENTISTRY

## FINANCIAL GUIDELINES

\_\_\_\_\_ I understand that payment is due at the time service is provided. Our office accepts cash, personal checks and all major credit cards. Outside financing is available upon request and approval. Please let us know if you would like more information about financing options.

\_\_\_\_\_ I understand that a finance charge of 1.5% monthly up to 18% annual interest will be added to my account monthly if my account is delinquent. I understand, that if not paid, my account will be turned over to the Credit Bureau and I will be responsible for all collection costs, court costs, attorney fees, and any additional delinquent billing fees or processing fees.

\_\_\_\_\_ I understand that returned checks will be subject to additional fees

## AUTHORIZATION TO DISCLOSE PROTECTED DENTAL INFORMATION AND ACCOUNT INFORMATION

I authorize Baker & Graham Family Dentistry to discuss my dental treatment and/or my account information with the following:

\_\_\_\_\_  
Name Relationship Phone Number

\_\_\_\_\_  
Name Relationship Phone Number

## INSURANCE PATIENTS

\_\_\_\_\_ I understand that Baker & Graham Family Dentistry is an Out of Network Provider with my insurance company.

\_\_\_\_\_ I have presented my insurance benefit card to the receptionist.

\_\_\_\_\_ I agree to pay the estimated amount not covered by my insurance company at the time of my service. I understand that this is an insurance estimate and it is not a guarantee that my insurance will pay exactly as estimated. My insurance company and my plan benefits ultimately determine the amount paid. I understand that I am responsible for any remaining balance within 30 days after my insurance company pays my claim.

\_\_\_\_\_ I understand that all charges incurred for me and my dependents are my responsibility regardless of my insurance coverage. I understand that you are my dental care provider and your relationship is with me and not my insurance company. My insurance policy is a contract between me, my employer, and my insurance company. Your office is not a party to that contract.

\_\_\_\_\_ By signing this form, I instruct my insurance company to pay directly to your office.

## I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS

\_\_\_\_\_  
PATIENT SIGNATURE OR PARENT OF CHILD

\_\_\_\_\_  
Date