



**Patient Information**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Gender Male \_\_\_ Female \_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ SINGLE MARRIED DIVORCED WIDOWED

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS# \_\_\_\_\_

Email Address \_\_\_\_\_ @ \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party**

Name of person responsible for this account (if **OTHER THAN YOURSELF**) \_\_\_\_\_

Relationship to patient \_\_\_\_\_ SS # \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Is this person currently a patient? YES NO

Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_

**Primary Dental Insurance Information**

Name of Primary Policyholder \_\_\_\_\_ Relationship to patient \_\_\_\_\_

SS# or Policyholder ID# \_\_\_\_\_ Group # \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Employer Name \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

**Secondary Dental Insurance Information**

Name of Primary Policyholder \_\_\_\_\_ Relationship to patient \_\_\_\_\_

SS# or Policyholder ID# \_\_\_\_\_ Group # \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Employer Name \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

**Dental History**

Reason for today's visit? \_\_\_\_\_ Are you on well water? **YES or NO**  
Former Dentist \_\_\_\_\_ Date of last dental visit? \_\_\_\_/\_\_\_\_/\_\_\_\_  
How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
Are you happy with your smile? **YES or NO** If no, please explain \_\_\_\_\_  
Do you have sensitivity in your mouth? **YES or NO** If yes, please explain \_\_\_\_\_  
Have you had any of the following?  Orthodontic Treatment  Denture/Partial  Gum treatment  Night Guard

**Medical History**

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Are you currently under physician's care? **YES or NO** If yes, please explain \_\_\_\_\_  
Have you had any hospitalizations, operations or major surgeries? **YES or NO** If yes, please explain \_\_\_\_\_

Do you require antibiotic prophylaxis for dental treatment due to any medical condition/surgery? **YES or NO**  
Are you currently taking or have you ever taken Bisphosphonates **YES or NO**  
**Women:** Are you pregnant? **YES or NO** If yes, due date \_\_\_\_/\_\_\_\_/\_\_\_\_ If no, are you taking oral contraceptive? **Yes or NO**

**Medications currently taking:** List any medications you are taking and correlating diagnosis

\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Latex  Local Anesthetic  Sulfa

Any other allergies? \_\_\_\_\_

**Habits**

Use tobacco Type? \_\_\_\_\_ How long? \_\_\_\_\_ How much per day? \_\_\_\_\_  
 Use alcohol? How much per WEEK? \_\_\_\_\_  Use Drugs \_\_\_\_\_

**Do you have or have you had any of the following?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV                 | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Arthritis, Rheumatism     |
| <input type="checkbox"/> Artificial Heart Valves  | <input type="checkbox"/> Artificial Joints              | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Back Problems                  | <input type="checkbox"/> Abnormal Bleeding         |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Chemotherapy                   | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Cortisone Treatments           | <input type="checkbox"/> Dental Anxiety            |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Epilepsy or Seizures           | <input type="checkbox"/> Fainting or Dizziness     |
| <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Heart Attack, Surgery, Disease | <input type="checkbox"/> Heart Murmur              |
| <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> Hepatitis Type _____           | <input type="checkbox"/> Headaches                 |
| <input type="checkbox"/> Herpes                   | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Jaundice                  |
| <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Low Blood Pressure        |
| <input type="checkbox"/> Lung Disease             | <input type="checkbox"/> Mitral Valve Prolapse          | <input type="checkbox"/> Parathyroid Disease       |
| <input type="checkbox"/> Psychiatric Care         | <input type="checkbox"/> Radiation Treatment            | <input type="checkbox"/> Respiratory Disease       |
| <input type="checkbox"/> Renal Dialysis           | <input type="checkbox"/> Rheumatic Fever                | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Shingles                 | <input type="checkbox"/> Sickle Cell Disease            | <input type="checkbox"/> Sinus Trouble             |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Stomach Disease                | <input type="checkbox"/> Intestinal Disease        |
| <input type="checkbox"/> Swollen Neck/Glands      | <input type="checkbox"/> Thyroid Disease                | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Tumors/Growths                 | <input type="checkbox"/> Venereal Disease          |

Any conditions not listed above? \_\_\_\_\_

**Signature of patient or parent:** \_\_\_\_\_

# SMILE SISTERS, LLC

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Suite 205  
Pasadena, MD 21122  
(410)768-7740

bakersisters.com



## Financial Agreement

Thank you for choosing our office. We are committed to providing you with the best possible care. If you have any questions regarding fees for treatment, please feel free to discuss them with us. We will make every effort to avoid misunderstandings and preserve our relationship.

Payment for services is due at the time treatment is rendered. If you have dental insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. We will be happy to process your insurance claims for reimbursement as well as accept insurance assignment from insurances we are participating providers with. Our office is provided with "general benefit" information from your insurance, which is not specific or a guarantee of benefits or payments. If for any reason your insurance denies a claim you will be responsible for the balance.

Your deductible if any and "estimated co-payment" are collected at the time of service. We cannot guarantee exact amounts to be paid by your insurance carrier. If there is any remaining balance after your insurance has processed your claim, the balance is your responsibility.

Missed and broken appointments waste valuable manpower and raise fees for everyone. In an effort to reduce this expensive waste there will be a charge of \$50 for broken or missed appointments. A broken appointment is classified as the failure to appear for an appointment, cancellations not made 48 hours in advance or lateness that results in an inability to complete scheduled treatment.

Returned checks due to insufficient funds or closed accounts will have a \$35 charge.

If your account must be placed in the hands of a third party for collections, your account will be charged 1/3 of the total balance for collection fees.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: \_\_\_\_\_

Date:

Relationship to Patient:

Response Date:

# Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, \_\_\_\_\_, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

**SMILE SISTERS, LLC**

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

## Patient or Personal Representative

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
Please Print

Relationship to Patient: \_\_\_\_\_

### For Office Use Only

We made a good-faith effort to obtain an acknowledgment of \_\_\_\_\_'s receipt of our *Notice of Privacy Practices*. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- Patient refused to sign (date of refusal) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Communications barriers prohibited obtaining an acknowledgment.
- An emergency situation prevented us from obtaining an acknowledgment.
- Other \_\_\_\_\_

Attempt was made by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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