CLASSIC SMILES
We love to care for your smile...

Susanne Inez Baaqee, D.M.D.
FAMILY, IMPLANT & COSMETIC DENTISTRY
Phone (407) 293-3002
Fax (407) 293-3004

Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

In Case of Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom can we thank for referring you to us? _____

Account Information

☐ Person responsible for this account is the same as above

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

☐ Additional Insurance

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _____ Date: _____

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Date: _____

Medical History

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank You!

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____
Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____
Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____
Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____
Please list any medications, pills, or drugs you are taking: _____
_____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Dialysis	☐ Other Serious Illness
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A, B, or C	☐ Rheumatic Fever	Please Explain:_____
☐ Anaphylaxis	☐ Drug Addiction	☐ Headaches	☐ Rheumatism	_____
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever	_____
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles	_____
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease	_____
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble	_____
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida	_____
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach Disease	_____
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Intestinal Disease	_____
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stroke	_____
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs	_____
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease	_____
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Problems	☐ Tonsillitis	_____
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tuberculosis	_____
☐ Chest Pains	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Tumors or Growths	_____
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcers	_____
☐ Congenital Heart Disease	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Venereal Disease	_____
☐ Convulsions	☐ Heart Trouble/Disease	☐ Recent Weight Loss	☐ Yellow Jaundice	_____

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____

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Susanne Inez Baaqee, D.M.D.
Family & Cosmetic Dentistry

Our Financial Policy

Patient Name: _____ Parent/Guardian Name_____

Thank you for choosing us as your health care provider. We strive to provide you with the best quality, gentle dental care possible. If we can help you in any way please don't hesitate to ask us.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/AMERICAN EXPRESS

Regarding Insurance:
Your insurance is a contract between you and the insurance company. We are not a party to that contract. Dental insurance is not meant to be a pay-all option but meant to be an aid. So please, be aware that some and perhaps all of the services provided under your particular policy may be considered **"Non-Covered Benefits"** above their **"Usual and Customary Fee"** or based on a set **"Fee Schedule".** Your benefits are dependant on how much your employer paid for your particular plan. If you have any questions regarding the detail of your plan, we ask that you contact your job. Regardless of what insurance pays, the final balance on your account is considered your responsibility. We are happy to assist you in receiving your maximum allowable benefits and require all pertinent insurance information to be given to us so that eligibility and general benefits can be verified. Once confirmed, our office will be able to accept assignment of benefits and bill your insurance company directly. Please understand that we cannot predict exactly what your insurance company will pay on a particular procedure or service and only an estimate can be determined of the charges based on the information your insurance company is willing to provide. An annual deductible and any required co-payment on a particular service will have to be collected at the time of service, and can only be based on the general information released by your insurance company. We will bill your insurance company as services are rendered. Payment is expected within 35 days of that billing. Any services not paid after the 45 day wait period will become immediately due in full. Accounts over 60 days past due will be subject to a monthly billing service charge.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Dental insurance usually covers Basic dental procedures. Complex comprehensive procedures and Cosmetics are often times **"Non –Covered Services".**

Change or Termination of Insurance:
If your insurance coverage changes or is terminated, please notify our office so we can update our information.

Returned Checks, Service Charge on Unpaid Balance:
We will be happy to accept your payment by check. For all returned checks there will be a maximum **service charge** from Secure Check Company. We also reserve the right to charge your account a monthly billing service charge on unpaid balances after 60 days.

Cancellation of Appointment:
If for any reason you are unable to keep your appointment, kindly give us 48 hours notice. Without 48 hours notice your account will be **charged a fee** of $50-$75 depending on how much time was blocked for your treatment after the **second** cancelled appointment.

I have had the opportunity to read this form, ask questions, understand and agree to the terms of the Financial Policy.

_____ _____
Signature of Patient or Legal Guardian Date

Susanne Inez Baaqee, D.M.D.
Family, Implant & Cosmetic Dentistry

TAKE THE CLASSIC SMILE TEST!

SMILE GRADING SYSTEM:

A. LOVE IT
B. ACCEPTABLE
C. COULD BE BETTER
D. DON'T LIKE IT
E. DON'T LIKE IT AT ALL
F. YES
G. NO

ARE YOU DELIGHTED WITH YOUR SMILE? _____

WOULD YOU LIKE YOUR TEETH TO BE WHITER? _____

*DO YOU HAVE A SMILE YOU LIKE TO SHOW OFF?*_____

*DO YOU EVER PUT YOUR HAND UP TO COVER YOUR SMILE?*_____

*DO YOU LIKE YOUR SMILE IN PHOTOGRAPHS?*_____

*ARE YOU EMBARASSED ABOUT SMILING IN FRONT OF PEOPLE?*_____

*ARE YOUR TEETH CROWDED OR DO YOU HAVE TO MUCH SPACE BETWEEN THEM?*_____

*WOULD YOU LIIKE A HEALTHY SMILE THAT WILL BOOST YOUR CONFIDENCE AND MAKE AN UNFORGETTABLE FIRST IMPRESSION?*_____

WOULD YOU LIKE TO? (PLEASE CHECK)

LIGHTEN ALL FRONT TEETH SHOWING_____LIGHTEN SINGLE TOOTH_____ELIMINATE DARK OR STAINED FILLINGS_____LENGTHEN_____SHORTEN_____CLOSE SPACES BETWEEN TEETH____REDUCE GUM SHOWING IN SMILE_____STRAIGHTEN ROTATION_____STRAIGHTEN ANGULATION_ _____ELIMINATE CROWDING_____

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT_____
_____

IF YOU WOULD LIKE TO IMPROVE YOUR SMILE PLEASE CALL OUR OFFICE TODAY AT 407-293-3002 TO SCHEDULE A PERSONAL COMPLIMENTARY CONSULTATION WITH DR BAAQEE.

Susanne Inez Baaqee, D.M.D.
Family, Implant & Cosmetic Dentistry

PATIENT SURVEY

THANK YOU FOR TAKING THE TIME TO COMPLETE OUR SURVEY. AFTER WE RECEIVE YOUR FEEDBACK, YOUR NAME WILL BE ENTERED INTO OUR MONTHLY DRAWING TO WIN AN ORAL-B ELECTRONOC TOOTHBRUSH.

Please rate your care today!

Who did you see today? **Doctor** _____
Hygienist _____

		Excellent	*Good*	*Fair*	*Poor*
1.	*Was your treatment gentle and comfortable?*	_____	_____	_____	_____
2.	*Are you happy with the dental work you received?*	_____	_____	_____	_____
3.	*Did you understand your treatment options?*	_____	_____	_____	_____
4.	*Were you able to ask questions and get helpful answers?*	_____	_____	_____	_____
5.	*Did your Provider seem competent and Knowledgeable?*	_____	_____	_____	_____
6.	*Were payment and insurance issues handled Well?*	_____	_____	_____	_____
7.	*Are our staff efficient, friendly and understanding?*	_____	_____	_____	_____
8.	*Were appointments quick and easy to make?*	_____	_____	_____	_____
9.	*Will you recommend us to others?*	_____	_____	_____	_____

Did we run on time? _____*If not was the wait time* *15-30 mins*_____*30-45mins*_____*over 45 mins*_____

Was any member of our staff particularly good or bad? (Please identify if possible) Do you have any comments or suggestions?

_____
_____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below Patient Name _____

1. **WORK TO BE DONE**

I understand that I am having the following work done: Fillings ____ Bridges ____ Crowns ____ Extractions _____ Impacted teeth removed _____ General Anesthesia ____ Root Canals _____ Other_____

Initials _____

2. **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).

Initials _____

3. **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of condition 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 permission to the dentist to make any/all changed and additions as necessary. **Initials** _____

4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery etc) and I authorize the dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, and some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days of months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials _____

5. **CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

Initials _____

6. **DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of acrylic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, include looseness, soreness and possible breakage. I realize the final opportunity to make changed in my new dentures (including shape, fit , size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of the procedure is not included in the initial denture fee.

Initial _____

7. **ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). **Initial** _____

8. **PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. **Initial** _____

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 question. My questions have been answered to my satisfaction. I am signing below that I have read and understood this form.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____

Susanne Inez Baaqee, D.M.D.
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Family & Cosmetic Dentistry

Hippa Acknowledgement Form

Our notice of Privacy provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care options as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name

(print) _____

(signature) _____

Date: _____