BAILEY DENTAL
17 County Road 68
Bailey, CO 80421
Phone: 303-838-2224

PATIENT INFORMATION

First Name_________________________ Last Name _________________________ Middle Initial _________

Preferred Name ________________________ Birthdate ______________________ SSN# _______________

Address_______________________________________City________________State______Zip___________

Sex ☐ M ☐ F Married/Domestic Partner ☐ Y ☐ N Student ☐ Y ☐ N

Is it okay if we text you reminders and other communications? ☐ Y ☐ N

How do you prefer we contact you: ☐ E-mail ☐ Phone ☐ Text Message

Cell #________________________ Home # _______________________ Work # ________________________

Email____

Employer_____________________________________ Occupation __________________________________

Who may we thank for referring you to our office? ____

Emergency Contact: ______________________________Phone#('s)__________________________________

RESPONSIBLE PARTY (*Fill-in only when someone other than the patient is responsible for the account)*

Name ___________________________________ Birthdate ___________________ SSN ________________

Address ___________________________________ City _________________ State _____ Zip ____________

Cell #________________________ Home # _______________________ Work # ________________________

Email____

Employer_____________________________________ Occupation __________________________________

Method of payment ☐ Cash ☐ Check ☐ Credit Card

PRIMARY INSURANCE INFORMATION

Name of Insured ____________________________________ Relationship to patient ____________________

Insured Birthdate _______________________ SSN ___________________

Employer _____________________________________ Occupation __________________________________

Name of Insurance______________________ ID# _____________________ Group # ____________________

Claims Address____ Phone # ____________________

SECONDARY INSURANCE INFORMATION

Name of Insured ____________________________________ Relationship to patient ____________________

Insured Birthdate _______________________ SSN ___________________

Employer _____________________________________ Occupation __________________________________

Name of Insurance______________________ ID# _____________________ Group # ____________________

Claims Address____ Phone # ____________________

Responsible Party's Signature ______________________________________ Date: ____________________

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Patient's Name:____

If there was one thing you could change about you smile, what would it be?

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

- ☐ Dentures (full or partial)
- ☐ Orthodontics (braces or clear aligners)
- ☐ Deep Cleanings, gum surgeries or been told you have "periodontal disease"
- ☐ A serious head or neck injury

Do any of the following apply to you now?

- ☐ Sensitivity to hot, cold, sweets
- ☐ Sensitivity or pain to biting/chewing
- ☐ Get food stuck between your tooth/teeth
- ☐ Cold sores/fever blisters
- ☐ Teeth and/or fillings that seem to be breaking or cracking frequently
- ☐ Wake up with headaches or sore jaw muscles
- ☐ Been told you grind
- ☐ Any other kind of consistent headaches/migraines
- ☐ Pain in your jaw joint(s)
- ☐ Bleeding or swollen gums
- ☐ Bad breath/taste in your mouth
- ☐ Shifting, loose or tipping tooth/teeth
- ☐ Sinus trouble/congestion
- ☐ Feel like your mouth is always dry, waking up several times at night thirsty, or always drinking water
- ☐ Always feeling tired, waking up a couple or several times at night, you feel like you can't get enough sleep
- ☐ Other: ____

On a scale from 1-10, 10 being the best:

How important is your dental health to you: 1 2 3 4 5 6 7 8 9 10
Where do you rate your personal dental health now: 1 2 3 4 5 6 7 8 9 10

Do you remember when was your last:

Cleaning/exam: _______/_______
X-rays: ______/______

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Patient's Name:____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Do you currently have a primary care provider? ☐ Yes ☐ No When was your last medical exam? ______/________

Have you ever been told you need to take antibiotics prior to a dental procedure? ☐ Yes ☐ No

Current Medications: ____

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications? ☐ Yes ☐No

Have you ever been admitted to the hospital or had a major surgery? ☐ Yes ☐ No

Please Describe: ____

Do you use Tobacco? ☐ Yes ☐ No If so, what kind? ☐ Chewing ☐ Cigarettes ☐ Vapor ☐ Cigars

How often: ______________________________

Do you use alcohol? ☐ Yes ☐ No If so, how often: ____

Do you use Marijuana/Controlled substances? ☐ Yes ☐ No If so, what kind and how often: _____________________

Women only, are you…. ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Any form of birth control

Allergies/adverse reactions to: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa drugs ☐ Seasonal/Hay Fever
☐ Acrylic ☐ Latex ☐ Metal ☐ Anesthetics ☐ Other: _______________

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

Asthma ☐ Yes ☐No Have you been admitted to the hospital for this? ☐ Yes ☐No
Do you have AND carry your rescue inhaler if you have one? ☐ Yes ☐No

Cancer ☐ Yes ☐No What kind? ____________________________________When? _______________
Chemotherapy? ☐ Yes ☐ No Radiation? ☐ Yes ☐No

Diabetes ☐ Yes ☐No Have you been admitted to the hospital for this? ☐ Yes ☐No
Do you have Type: ☐ 1 ☐ 2 Do you know your Ha1C? ________

High Blood Pressure ☐ Yes ☐No Have you been admitted to the hospital for this? ☐ Yes ☐No

AIDS/HIV Positive	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Dialysis	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Hepatitis B/C	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hives/Rash	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Fainting/Dizziness	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Stomach Issues	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Swelling of limbs	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Liver Disease/Jaundice	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tumors/Growths	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cortisone/Steroids	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Drug Addiction	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No		

Notes/Other:

Patient: ____________________________________ Dentist: ____________________________________
Signature Date Signature Date

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We are excited that you have decided to join the Bailey Dental family! The care of your oral health and well-being is our number one priority. We hope that your experience far exceeds that of any other office that you have been to in the past. If there is anything that we can do to make your dental experience better, please let us know. In an effort to improve your experience here, the following are designed to make your visit smoother, more efficient, and put a smile on your face!

APPOINTMENTS

Unlike most offices, we do not overbook our schedule to anticipate cancellations or no-shows. We know that your time is just as valuable as ours. The time that we schedule for you is your special time reducing your time in the waiting area, in the treatment chair, and gets you going for the rest of your day in a timely manner.

We understand that emergencies may happen from time to time. When there is not a big last-minute emergency, we ask that you talk to us about changing an appointment **no later than 48 hours before your appointment.** There is a cancellation and rescheduling fee of $40.00 for each appointment cancelled or missed within 48 hours. It can also be difficult if we need to move an appointment to a different time on the same day. Please help us keep the schedule on time and without last minute cancellations so we may continue to have your valuable appointment time set aside just for you.

YOUR INSURANCE

If you have any type of dental coverage, you have a great tool that can help with your dental care. We will do everything we can to get benefit information from your insurance company and help you understand how your insurance can help you. You authorize any and all information we have collected, under the Healthcare Information Portability and Accountability Act of 1996, to send to the insurance company to aid in payment of services rendered. It is important to understand that **insurance is not meant to pay for all of your dental care, but act as a tool to reduce the amount you pay.** An insurance company may say that something is or is not covered, but it is not until they receive a claim from us that they will make a determination on your benefits. We will file claims for you, as a courtesy, to your insurance company. We do ask that you **pay your deductible and copay or percentage at the time of your appointment**. This is an estimate, until the insurance company has rendered its decision on payment of your claim. However, if your insurance company fails to pay the benefit in 60 days, we ask that you pay the amount in full.

We do our best to spend time with who is most important: You!

COLLECTIONS

Unless patients have made prior arrangements, all payments are due at time of service. We accept checks, MasterCard, Visa, Discover and American Express. Bailey Dental has a returned check fee of $40 regardless of the amount of the check. We have financing options through Care Credit and Lending Club. Keep in mind all payment options may not be available for all procedures. Check with our office for additional details.

Any account balance(s) that are not paid by 30 days from the date of the procedure may initiate the collections process. You will receive a 30 day's notice as required by Colorado State law *(Bill 04-1285)* prior to being turned over to collections. Any of the information collected by our office, including obtaining a credit report, may be used by the collection agency. If payments are made, they will be to the collection agency in the payment forms they accept. These payments usually incur additional fees to the amount already owed. Should litigation be necessary to collect an amount owed, the responsible party(s) agree to pay all costs of collection including, but not limited to collection fees, attorney fees, and interest rate of 18%.

Responsible Party's Signature ____ Date: _____________________

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ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy (if requested) of this Dental Practice's Notice of Privacy Practices.

Please Note: It is your right to refuse to sign this Acknowledgement.

Patient Name (Please Print) ____

Patient/Responsible Party Signature ___________________________________ Date ____________________

Authority/Relationship of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: __________________________

OFFICE STAFF USE ONLY

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- □ An emergency prevented us from obtaining acknowledgement.
- □ A communication barrier prevented us from obtaining acknowledgement.
- □ The individual was unwilling to sign.
- □ Other: ____

Employee Name (Please Print) ______________________________________

Employee Signature ____ Date ______________________