BARON DENTAL CARE

PATIENT MEDICAL HISTORY FORM

Staff Initials: _____

2225 N. Jerusalem Road, East Meadow, NY 11554
Phone: 516.481.4111 • Fax: 516.481.4593

Patient Name: _____ Date of Birth: _____ Date: _____

Address: _____

Phone: _____ Cell: _____ Email: _____

Medical

	Yes	No	DK
Has there been a major change to your health within the past year?	☐	☐	☐
If yes, please explain: _____			
Are you under the care of a physician or are you receiving ongoing medical care?	☐	☐	☐
Name of your physician: _____			
Physician's Phone Number: _____			
Date of your last medical visit: _____			
Are you pregnant?	☐	☐	☐
If Yes, due date: _____			
Do you breast feed?	☐	☐	☐
Do you have any artificial joints, heart valves, implants, or prosthesis?	☐	☐	☐
Have you ever been told you need to be pre-medicated prior to dental treatment?	☐	☐	☐
Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?	☐	☐	☐
If yes, please explain: _____			

Dental

	Yes	No	DK
Are you having any dental discomfort at this time?	☐	☐	☐
If yes, please explain: _____			
Have you ever had serious trouble with previous dental work?	☐	☐	☐
If yes, please explain: _____			
Does dental work make you nervous?	☐	☐	☐
Have you ever had any abnormal bleeding associated with previous extractions, surgery or trauma?	☐	☐	☐
If yes, please explain: _____			
Date of your last dental visit: _____			
How often do you brush your teeth: _____			
How often do you floss your teeth: _____			

Other

Please check the answer that is right for you "Yes" No" "DK" (Don"t Know)

	Yes	No	DK		
Do you use tobacco?	☐	☐	☐	What?_____	How much____
Do you use alcohol	☐	☐	☐	What?_____	How much____
Do you have any CURRENT/PAST history of substance abuse?	☐	☐	☐	If yes, please explain: _____	

Medications

Are you taking any prescriptions or over the counter medications? Yes ☐ No ☐ DK ☐

Please list all medications you are taking (Please include prescription and non-prescription medications):

	Medication:	Dosage:	How Often Taken:	Reason for Medication:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Allergies

Are you allergic to anything? Yes ☐ No ☐ DK ☐

Please list all allergies including reaction:

	Allergy to:	Reaction:
1.		
2.		
3.		
4.		

Patient Medical History Form

Date of Birth: _____ Date: _____

Medical Information:
Please check the answer that is right for you "Yes" No "DK"(Don"t Know)

Heart and Circulatory Problems

	Yes	No	DK
Heart Attack	☐	☐	☐
If yes, when: _____			
High Blood Pressure	☐	☐	☐
Chest Pain (Angina)	☐	☐	☐
Heart Murmurs	☐	☐	☐
Artificial Valves	☐	☐	☐
Other Heart Problems	☐	☐	☐
Comments: _____			

	Yes	No	DK
Diabetes - Type I	☐	☐	☐
Diabetes - Type II	☐	☐	☐
Thyroid Problems	☐	☐	☐
Other Gland Problems	☐	☐	☐
Comments: _____			

Breathing/Lung Problems

	Yes	No	DK
Hay Fever	☐	☐	☐
Shortness of Breath	☐	☐	☐
Persistent Cough	☐	☐	☐
Positive Test/Treatment for Tuberculosis	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Coughing up Blood	☐	☐	☐
Comments: _____			

Skin Problems

	Yes	No	DK
Rashes	☐	☐	☐
Mole Changes	☐	☐	☐
Comments: _____			

Stomach Problems

	Yes	No	DK
Stomach Pain	☐	☐	☐
Heartburn	☐	☐	☐
History of Ulcers	☐	☐	☐
Colitis	☐	☐	☐
Comments: _____			

Mental Health Problems

	Yes	No	DK
Depression	☐	☐	☐
Anxiety	☐	☐	☐
History of Psychiatric Medications	☐	☐	☐
Comments: _____			

Muscle and Bone Problems

	Yes	No	DK
Joint/Back Pain	☐	☐	☐
History of Broken Bones	☐	☐	☐
Joint Swelling	☐	☐	☐
Arthritis	☐	☐	☐
Comments: _____			

Liver

	Yes	No	DK
Hepatitis A, B, or C	☐	☐	☐
Alcoholic Liver Disease	☐	☐	☐
Other Liver Disease	☐	☐	☐
Jaundice	☐	☐	☐
Comments: _____			

Neurologic Problems

	Yes	No	DK
Epilepsy/Seizures	☐	☐	☐
Chronic Headaches	☐	☐	☐
History of Head Injury	☐	☐	☐
Numbness of Arms, Legs, Hands or Feet	☐	☐	☐
History of Stroke	☐	☐	☐
If yes, when _____			
Fainting Spells	☐	☐	☐
Comments: _____			

Blood Problems

	Yes	No	DK
Bleeding Problems	☐	☐	☐
Anemia	☐	☐	☐
Hemophilia	☐	☐	☐
Are you taking blood thinnners?	☐	☐	☐
If yes, recent INR level _____			
Comments: _____			

Other

	Yes	No	DK
Domestic Abuse	☐	☐	☐
Immune System Disorders	☐	☐	☐
Venereal Disease	☐	☐	☐
AIDS/HIV	☐	☐	☐
Kidney or Bladder Problems	☐	☐	☐
Frequent Urinary Tract Infections	☐	☐	☐
Comments: _____			

Do you have any other disease, condition or problem not listed? ☐ ☐ ☐

If Yes, please explain_____

I understand that to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to Baron Dental Care.

We set aside this time just for you. If you're running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. If you miss two appointments, you may only be able to make same-day appointments. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment. These rules are firm so that we can server everyone in need of care.

Signature of Patient or Guardian Date

Signature of Hygienist

☐ Not Applicable

Signature of Dentist Date

☐ Supervising ☐ Treating

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with his restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of_____, 20_____

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

Baron Dental, L.L.C.
2225 North Jerusalem Road
East Meadow, NY 11554

AUTHORIZATION TO USE SIGNATURE ON FILE

INSURED NAME:_____

INSURED ADDRESS:_____

INSURED ID# OR SS#:_____

EFFECTIVE DATE OF AUTHORIZATION:_____

To Whom It May Concern:

I request that payment under the dental insurance program to be made to the provider **BARON DENTAL LLC** on any bills or services furnished to me during the effective date of this authorization.

I authorize the words "Signature on File" in place of my signature on claim forms to authorize release of any information relating to this claim for the purpose of making payment.

I have read and understand the following New York State mandated Insurance Claim Fraud Notice:

Any person who knowingly and with the intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to civil and criminal penalties.

Signature:_____Date:_____

Print Name:_____

Optional assignment of benefit authorization_I authorize payment to be made Directly to the provider named on above and on the claim form which would be otherwise payable to me.

Signature:_____Date:_____

Print Name:_____

Baron Dental, LLC
Matthew J. Baron, DMD
Alexandra Lauterborn, DDS

2225 N. Jerusalem Rd. East Meadow, NY 11554 516-481-4111

Office Financial Policy

Total payment for treatment is due upon completion of treatment. Most insurance benefits can be assigned to the office toward treatment costs. Baron Dental LLC *is not* employed by any insurance company. Patients are responsible for all information that pertains to their policy. *Insurance estimates are estimates only* and can be changed by your carrier at their will. *Please be advised that you are ultimately responsible for the entire treatment balance.* Most insurance carriers *do not* cover 100% of treatment costs, you are responsible for all co-pays.

Any balance after *60 days* is subject to a *1.5% interest charge per month or 18% annually* thereafter.

Collection costs: If you are in default under this note and Baron Dental LLC demands full payment, you agree to interest on the unpaid balance at the rate stated above. If Baron Dental LLC has assigned your account to an attorney, you agree to pay 25% of the unpaid balance plus interest for the attorney's fees and will pay court costs. Also, you agree to pay 25% of the collection agency fees of the unpaid balance plus interest, if your account is assigned to a collection agency.

Office Cancellation Policy

Appointments missed without 24-hour notice for weekday appointments, and 48-hour notice for Saturday appointments will be charged a cancellation fee of $50 per half-hour missed.

Patient/ Guarantor: _____

Thank you,

Baron Dental LLC

INSURANCE UPDATES & NEW PATIENT FORM

PLEASE DO NOT LEAVE ANYTHING BLANK

Without all of the necessary information we cannot submit your insurance for you

Patient Information

Patient Name: _____

Patient Address: _____

Patient Phone: _____Business Phone:_____

Patient SS #:_____ - _____-_____ Patient D.O.B: _____

Pre- Medicate: Yes/No Referred By:_____

Email: _____

Insurance Information

Insurance Company Name:_____

Insurance Co Address:_____

Insured Name:_____ Insured Co. Phone:_____

Insurance ID Number:_____

Group Number:_____

Insured Employer:_____

Insured D.O.B.: _____/_____/_____Insured SS #: _____ - _____-_____