Baker Dental Studio

PATIENT INFORMATION

Name_____Date of Birth_____Age_____
Last First Middle

Name Parent/Guardian if minor_____

Address_____Apt#_____ Sex ☐ M ☐ F

City_____State_____ Zip Code_____

Home Phone ( ) _____Cell Phone ( )_____

Work Phone ( )_____

Social Security Number_____E-Mail Address_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Spouses Name_____

*Who may we thank for referring you?*_____

In case of emergency who should be notified?_____ Phone ( )_____

Primary Dental Insurance

Subscriber/Employee Name_____Relationship to patient_____

Social Security or ID #_____Subscriber Date of Birth_____

Insurance Company_____Group #_____

Insurance Company Phone ( )_____

Employer Name_____

Secondary Dental Insurance

Is Patient covered by additional insurance? ☐ Yes ☐ No

Subscriber/Employee Name_____Relationship to patient_____

Social Security or ID #_____Subscriber Date of Birth_____

Insurance Company_____Group #_____

Insurance Company Phone ( )_____

Employer Name_____

OVER →

PATIENT HEALTH RECORD

Do you now have or have you had any of the following? **(Please Mark ALL boxes Yes OR No)**

	Yes	No		Yes	No
Artificial Joint(hip/knee)	☐	☐	Diabetes	☐	☐
Heart Disease	☐	☐	Ulcers	☐	☐
Rheumatic Fever	☐	☐	Epilepsy	☐	☐
Cancer	☐	☐	Arthritis	☐	☐
Positive HIV	☐	☐	Anemia	☐	☐
Heart Murmur	☐	☐	Tumors/Growths	☐	☐
Hepatitis	☐	☐	Pacemaker	☐	☐
Kidney Disease	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Radiation	☐	☐
High Blood Pressure	☐	☐	Chemotherapy	☐	☐
Blood Transfusion	☐	☐	Emphysema	☐	☐
Hemophilia	☐	☐	Stroke	☐	☐
High Cholesterol	☐	☐	Liver Disease	☐	☐
Depression	☐	☐	Mitral Valve Prolapse	☐	☐
Anxiety	☐	☐	Mitral Valve Replacement	☐	☐
ADHD/ADD	☐	☐	GERD/Acid Reflux	☐	☐

MEDICAL CONDITION(S) NOT LISTED ABOVE: _____

_____ _____ _____

Are you taking any drugs or medications? If so, what and what dosage?

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Are any of the medications listed above a blood thinner?_____

Are you allergic, or have had any unusual reaction to any drug? If so what drug?

_____

Physician Name_____Date Last Seen_____

Are you now being treated by a physician or any healthcare professional? If so please explain_____

Do you smoke? How much/often? _____

FEMALES: Are you pregnant?_____ If so, when is your due date?_____

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor. Also, if I have any questions about any procedure, I may ask the doctor or any staff member of any time. I authorize treatment of the person named above and agree to pay all fees and charges at the time of treatment, unless credit arrangements are agreed upon in writing. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days of the billing date. In the event legal action should become necessary to collect an unpaid balance due for dental treatment rendered to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determined proper, I/we also agree that the matter be litigated in the 61st District Court (Grand Rapids). It is also agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

Signature_____**Date**_____