Dennis Baik DDS
Cosmetic, Implant & Sedation Dentistry

Patient Registration

❖ About You

Name: _____ Today's Date: _____
I like to be called: _____ Date of Birth: _____
Social Security #: _____ Driver's License #: _____
Marital Status: |Single |Married | Divorced | Widowed |Other, Spouse's Name:
_____
Employer: _____ Occupation: _____
Whom may we thank for referring you? _____
Special Interests or Hobbies: _____

❖ Contact Information

Home Address: _____ City, State, & Zip: _____
Home Phone: _____ Work Phone: _____
Email: _____ Cell Phone: _____
In case of an emergency, who may we contact on your behalf?
Name: _____ Phone: _____

❖ Responsible Party Information

(Please fill out if different from above)
Name: _____ Relation to Patient: _____
Social Security #: _____ Driver's Lic. #: _____
Home Phone: _____ Work Phone: _____
Home Address: _____ City, State, & Zip: _____

❖ Insurance Information

Primary Dental Insurance:
Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____
Additional Dental Insurance
Name of Insured: _____ Relation to patient: _____
Insured's Birth Date: _____ Insured's SSN: _____
Insured's Employer: _____ Group/policy #: _____
Insurance Plan Name: _____ Insurance Phone #: _____
Insurance Address: _____

Office Policy/Financial Responsibility Statement

1. I verify and understand that I am fully responsible for the fees and charges from my dental services provided by Dr. Dennis Baik whether they are paid by my insurance or not.

2. Full payment or ***estimated*** co-payment of insurance is due at the time of the services.

3. It is my responsibility to inform the office of Dr. Dennis Baik if there is a change in my insurance status.

4. I understand that the office of Dr. Dennis Baik reserves the right to charge for duplicating and sending any dental records (including digital records such as dental x-rays) to me or to other healthcare providers whom I designate.

5. If after 90 days the insurance carrier had not paid a claim, it will then be my responsibility to pay the balance to Dennis Baik, DDS and collect from the insurance carrier directly.

6. I understand that as a **courtesy,** office of Dennis Baik, DDS will process my insurance claims. Nevertheless, I am fully aware that I am ultimately responsible for any portions not covered by my insurance

7. I will give at least 48 hours advance notice to the office of Dennis Baik, DDS for any cancellation or changes to my appointment.

Our office reserves the right to charge for appointments cancelled or broken without a full 48 hours advance notice.

8. **ASSIGNMENT AND RELEASE OF INSURANCE BENEFIT**

I certify that I, and/or my dependent(s), have dental insurance coverage with

_____ and assign directly to Dr. Dennis Baik all
Name of Insurance company(ies)

insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I further authorize Dr. Baik to disclose my health care information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Name of Patient (Print):_____

Name of Responsible Party: _____ _____
Relationship to Patient

Signature of Responsible Party:_____ Date:_____

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Medical and Dental History

❖ Health Information

Name:_____ Age: _____ | Male | Female

Name of Personal Physician: _____ Physician's Phone #: _____

Date of Last Medical visit: _____ Current Health: |Excellent |Good Fair Poor

Please check 'yes ' or "no" to indicate which of the following conditions you have had or currently have

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Diabetes			Latex Allergy		
Allergies			Dizziness/Fainting			Liver Disease		
If yes, what?_____			Emphysema			Low Blood Pressure		
Anemia			Excessive Bleeding			Nervous Disorder		
Arthritis/Rhematism			Epilepsy (Seizure)			Pacemaker		
Artificial Heart Valves			Glaucoma			Psychiatric Care		
Artificial Joint			Growths/Tumor			Radiation treatment		
Asthma			Heart Disease			Respiratory Problem		
Blood Disease			Heart Murmur			Shortness of Breath		
Cancer			Heart Transplantation			Sinus Problems		
Chemical Dependency			Hepatitis Type_____			Stroke		
Congentl Heart Disease			Herpes			Tuberculosis		
(Unrepaired cyanotic)			High Blood Pressure			Taken Fen-Phen ?		
Currently Pregnant?			Infective Endocarditis			Taken Bisphosphonates?		
If yes, due date:_____			Jaundice			(e.g. Fosamax, Actonel, or Didronel)		
Currently nursing?			Kidney Disease			Ulcers/Stomach Prob.		

- Do you have any medical conditions not listed above? ☐ Yes ☐ No

If yes, please explain: _____

- Are you taking any medications (including herbal)? ☐ Yes ☐No

If yes, please list:_____

- Are you allergic to any medications? ☐ Yes ☐No

If yes, please list:_____

- Have you been hospitalized within last two years? ☐ Yes ☐ No

If yes, please explain:_____

- Do you smoke or use chewing tobacco? ☐ Yes ☐ No, If yes, how much?____
- Have you ever been diagnosed with **O**bstructive **S**leep **A**pnea? Yes No
- Has anyone complained about your snoring? Yes No
- Do you often feel tired, fatigued, or sleepy during daytime? Yes No
- Has anyone observed you stop breathing during your sleep? Yes No

Patient Initial _____

❖ Dental History

Reason for today's visit: _____

Former Dentist:_____ City/state:_____

Date of last dental visit_____ Reason for the visit:_____

*Indicate which of the following you have at present. Check **"yes"** or **"no"** to each item*:

	Yes	No		Yes	No		Yes	No
Bad breath			Orthodontic treatment			Sensitivity to cold		
Bleeding gums			Fingernail biting			Sensitivity to heat		
Gums swollen or tender			Lip or cheek biting			Sensitivity to sweets		
Periodontal treatment			Mouth breathing			Sensitivity when biting		
Clicking or popping jaw			Burning sensation on Tongue			Food collection between the teeth		
Grinding teeth			Sores or growths in your mouth			Loose teeth or broken fillings		
Jaw pain or tiredness			Blisters on lip or mouth			Dry mouth		
Chew on one side of mouth								

How often do you floss?_____ How often do you brush?_____

Have you ever had any complications following dental treatment? □Yes □No

If yes, please explain:_____

Please RANK the following in the order of what would PREVENT YOU from receiving proper dental treatment

_____FEAR _____ COST _____LACK of concern _____ MISSING work time

❖ Smile Evaluation

*Please check "**yes**" or "**no**" to each item in order to evaluate your smile:*

	Yes	No		Yes	No
Are there any aspects of your smile that you are not happy about?			Do you have any spaces between your teeth that you don't like?		
Would you like to change the color of your teeth?			Are any of your teeth chipped/cracked?		
Do you have any concerns about the alignment/shape of your teeth?			Do you have fillings or dental work that you don't like looking at?		

If you answered yes to any of above questions, please explain_____

_____

The preceding information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and only be used to improve communication between Dr.Baik and myself. I also authorize Dr.Baik to contact my family physician and/ or my other medical specialist that I have listed above to obtain further medical information, if necessary.

Patient Signature:_____ Today's Date:_____

Dr. Signature:_____ Today's Date:_____

Updated: 2014-09-11