Bryan S. Baker, D.D.S., Inc.
Maxillofacial Prosthodontics

Patient Name: Birth Date:

Patient Address: City: State/Zip:

Patient Home Phone: Patient Work Phone: Patient Cell Phone:

Primary Physician's Name: SS#:

Major dental problem or reason for coming:

Patient's e-mail: May we e-mail appointment reminders?

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

MEDICAL

Y N Is your general health good?
Y N Has there been a change in your health within the last year?
Y N Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
Y N Have you been under the care of a physician during the past two years?
Y N Have you taken any prescribed medicine or controlled drugs during the past two years?
Y N Have you ever been on a medically supervised diet using Fen-Phen (fen-fen)?

DENTAL

Please list the date of the following:

a. Dental Exam _____ c. Dental Cleaning _____
b. Dental X-rays _____ d. Periodontal Care _____

Y N Are you in pain
Y N Have you ever had a bad experience in a dentist's office?
Y N Has a physician told you that you require antibiotics before dental treatment?

Medical Information:

II. HAVE YOU EXPERIENCED:

Y	N	Chest pain (angina)?	Y	N	Dizziness?
Y	N	Swollen ankles?	Y	N	Ringing in ears?
Y	N	Shortness of breath?	Y	N	Headaches?
Y	N	Recent weight loss, fever, night sweats?	Y	N	Fainting spells?
Y	N	Persistent cough, coughing up blood?	Y	N	Blurred vision?
Y	N	Bleeding problems, bruising easily?	Y	N	Seizures?
Y	N	Sinus problems?	Y	N	Excessive thirst?
Y	N	Difficulty swallowing?	Y	N	Frequent urination?
Y	N	Diarrhea, constipation, blood in stools?	Y	N	Dry mouth?
Y	N	Frequent vomiting, nausea?	Y	N	Jaundice?
Y	N	Difficulty urinating, blood in urine?	Y	N	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

Y	N	Heart disease?	Y	N	HIV/AIDS?
Y	N	Heart attack, heart defects?	Y	N	Tumors, cancer?
Y	N	Heart murmurs?	Y	N	Arthritis, rheumatism?
Y	N	Rheumatic fever?	Y	N	Eye diseases?
Y	N	Stroke?	Y	N	Skin diseases?
Y	N	Hardening of arteries?	Y	N	Anemia?
Y	N	High blood pressure?	Y	N	VD (syphilis or gonorrhea)?
Y	N	Asthma, TB, emphysema, other long disease?	Y	N	Herpes?
Y	N	Hepatitis, other liver disease?	Y	N	Kidney, bladder disease?
Y	N	Stomach problems, ulcers?	Y	N	Thyroid, adrenal disease?
Y	N	Family history of diabetes, heart problems, tumors?	Y	N	Diabetes?

Medical Information:

I. DO YOU HAVE OR HAVE YOU HAD:

Y	N	Psychiatric care?	Y	N	Hospitalization?
Y	N	Radiation treatments?	Y	N	Blood transfusions?
Y	N	Chemotherapy?	Y	N	Surgeries?
Y	N	Prosthetic heart valve?	Y	N	Pacemaker?
Y	N	Artificial joint?	Y	N	Contact lenses?

II. ALLERGIES - DO YOU HAVE OR HAVE YOU HAD:

Y	N	Foods	Y	N	Dental Anesthetic?
Y	N	Antibiotics (Penicillin)	Y	N	Metals?
Y	N	Sulfa Drugs	Y	N	Latex?
Y	N	Aspirin	Y	N	Others (Specify)

III. ARE YOU TAKING OR HAVE YOU TAKEN:

Y	N	Recreational drugs?	Y	N	Tobacco in any form?
Y	N	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	Y	N	Alcohol?

Please list: _____

_____

IV. WOMEN ONLY:

Y	N	Are you or could you be pregnant or nursing? If so, please give due date _____
Y	N	Are you nursing _____
Y	N	Are you in or have you passed through menopause (change of life)?
Y	N	Are you taking hormones?
Y	N	Are you taking Bisphosphonates?
Y	N	Taking birth control pills?

V. ARE YOU TAKING:

Y	N	Recreational drugs?	Y	N	Tobacco in any form?
Y	N	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	Y	N	Alcohol?

VI. ALL PATIENTS:

Y N Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

List all prescription and non-prescription drugs (including aspirin) taken within the last 6 months:

Name	Dosage	Name	Dosage
1.		3.	
2.		4.	

Please list all hospitalizations and emergency room visits (include dates and reasons):

1.	4.
2.	5.
3.	6.

Have you been dissatisfied with previous dental treatment? _____ YES _____ NO

If yes, please describe: _____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

RECALL REVIEW:

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____

Responsible Party Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext.: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street Apartment #

_____

City State Zip Code

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY _____ GROUP NUMBER _____

SECOND (DUAL) INSURANCE CO. _____ GROUP MEMBER _____

SECOND INSURANCE SUBSCRIBER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to BRYAN S. BAKER, D.D.S., INC. 1213 MANHATTAN AVENUE, MANHATTAN BEACH, CA 90266, assigning directly to Dr. Baker all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor or his staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all benefits submissions.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Consent for Services
PLEASE READ AND SIGN BELOW

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursements from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party