Bay Area Denture and Surgery Center

Dr Dennis Van Maren, DDS

5733 South Padre Island Drive, Suite A

Corpus Christi, TX 78412

361-857-6200

NEW PATIENT INFORMATION

Patient Name: _____ **Date:** _____

Who is your primary care dentist? _____

Have you ever been diagnosed with periodontal disease? ☐ **Y** ☐ **N** If yes, when were you diagnosed? _____

Are you wearing any dental appliances such as a full denture or partial right now? _____

HOW DID YOU HEAR ABOUT US?

How did you hear about our office? FACEBOOK_____ **ON OUR WEBSITE**_____

Television Advertisement seen on: KIII/ABC _____ **KRIS/NBC** _____

A Billboard Advertisement _____ **KRIS/NBC**_____

Yellow Page Advertisement/ Phone Book AD _____ **A Friend we've Helped**_____

A Local Physician Referral _____

Other? Who may we thank for referring you? _____

Find Us on Facebook www.facebook.com/bayareadenture**, or our website** www.bayareadenture.com

BAY AREA DENTURE And SURGERY CENTER – NEW PATIENT INFORMATION

Patient Name (First, Middle Initial, Last)	Social Security Number	Primary Phone (cell, Home, Work)
Home Address	City, State, Zip Code	Date of Birth (Mo/Day/Year)
Email Address	Dental Insurance/ Subscriber #	Employer / Contact number

Marital Status:	Sex:	Responsible Party
☐ Married ☐ Single ☐ Widowed ☐ Other	☐ Male ☐ Female	☐ Self ☐ Other (if other, complete section below)

RESPONSIBLE PARTY:

Patient Name (First, Middle Initial, Last)	Social Security Number	Primary Phone (cell, Home, Work)
Home Address	City, State, Zip Code	Date of Birth (Mo/Day/Year)
Email Address	Dental Insurance/ Subscriber #	Employer / Contact number

CONSENT: I have answered all health questions to the best of my knowledge _____
(signature of Patient or responsible party)

After explanation by the doctor, **I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may decide in order to carry out said procedures.** I also authorize any request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

TERMS AND CONDITIONS: This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibilities of each patient must be determined before treatment begins.
As a condition of treatment, by this office, I understand that financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time services are performed.

I UNDERSTAND that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms and/or submit them on my behalf; however, I am personally responsible for paying for my treatment.

SIGNATURE	DATE	RELATIONSHIP TO PATIENT

bay area DENTURE AND SURGERY CENTER

PATIENT NAME_____

We understand the cost of dental treatment is an important investment for many people. At Bay Area Denture and Surgery Center we are committed to providing high-quality, affordable care. To help make this financially available to everyone who walks in our door, we offer different payment options that the majority of our patients, just like you, take advantage of. In fact, at Bay Area Denture and Surgery Center everyone is guaranteed 100% approval for financing. To shorten your exam wait time and make it as easy as possible for you, please fill out the information below to help us more quickly find the best payment options for you.

Responsible Party Information

First Name _____ Middle Initial _____ Last Name _____ Gender F / M

Social Security # ___-___-___ Date of Birth ___/___/___ Home Phone (___)___-___ Cell Phone (___)___-___

Mailing Address (Including Apt #) _____ Best Time To Be Reached:_____AM/PM

City _____ State ____ Zip _____ Email Address _____

Driver's License: #_____ State:_____ Expiration_____/_____/_____

Income & Employment Information

Gross Monthly Household Income: $_____ Source of Income: Employed / Self Employed / Retired /Other:_____

Present Employer_____How Long?_____Present Employer Phone #:(___)___-___

Residential Status: Own / Rent / Live with others / Other:_____ How long at current address?_____

Monthly Rent/Mortgage Payment: $_____ Marital Status: Single / Married / Other _____

Emergency Contact Name_____Phone #:(___)___-___

By signing below you are giving Bay Area Denture and Surgery Center the right to process a credit application with Cura ONE, Care Credit, and Boston Credit Corp., where the responsible party information listed above will be utilized for these applications.

****DO YOU PRESENTLY HAVE AN AVAILABLE Cura ONE, Care Credit OR Boston Credit Corp Account?**

☐ **NO** ☐ **YES** **If YES, explain:**_____

_____ _____/_____/_____

Responsible Party Signature **Date**

Bay Area Denture and Surgery Center Patient Medical History

Patient's Dental Health

Why have you come to see us today? (example; pain, broken denture, etc.)

_____

What was the date of your last dental visit? _____

Are you nervous about seeing the dentist today? ___ Y ___ N ; if so, please tell us why :

_____

How often do you brush your teeth? _____

Y N I clench or grind my teeth during the day or while sleeping

Y N My gums feel tender or swollen

Y N My gums bleed while brushing or flossing

Y N I have problems eating

Y N I have had a facial or jaw injury

Y N I avoid brushing part of my mouth due to pain

Patient's Medical History

I consider my health to be (please check one): ____Excellent ____Good ____Fair ____Poor

Y N Heart Disease

Y N Heart Valve Replacement

Y N Stroke

Y N Asthma

Y N Kidney Disease

Y N Allergies

Y N Hearing loss

Y N Tuberculosis

Y N Cancer

Y N Sinus Problems

Y N Epilepsy

Y N Glaucoma

Y N Anemia

Y N Herpes

Y N Diabetes

Y N AIDS

Y N High Blood Pressure

Y N Fainting Spells

Y N Lung Disease

Y N Chemotherapy

Y N Radiation Therapy

Y N Seizures

Y N Implants/artificial joints

Y N jaundice

Y N Liver disease

Y N Excessive Urination

Y N prolonged bleeding

Y N History of drug addiction

Y N do you smoke

Y N Immune suppressed

Y N Do you take antibiotics before dental treatment?

Y N Have you taken Fen-Phen or Redux?

Y N Tumor or Malignancy

Y N Hepatitis – A B or C

Y N Congenital Heart Lesions

Next 2 Questions For Women Only:

Y N Are you taking birth control

Y N Are you pregnant?

Bay Area Denture and Surgery Center Patient Medical History

Y N I have had major surgery: Year_____ Type of procedure_____

Year_____ Type of procedure_____

Year_____ Type of procedure_____

Year_____ Type of procedure_____

Y N Do you have any medical problem or medical history not listed on this form that you'd like to let us know about?_____

_____

Patient Allergies

Are you allergic to any of the following?

Y N Aspirin Y N Ibuprofen Y N Sulfa Drugs / Sulfites / Sulfides

Y N Penicillin Y N Codeine Y N Latex

Y N Plastics Y N Metals (Which ones) _____

Y N Local Anesthetics – Novocain or others? _____

Y N Medications not listed – Which ones? _____

_____

Please list all medications you currently take. If you brought a list, we can put a copy of it in your record at your request.

Medication_____Dose_____Frequency_____

Medication_____Dose_____Frequency_____

Medication_____Dose_____Frequency_____

Medication_____Dose_____Frequency_____

Medication_____Dose_____Frequency_____

Should you require emergency assistance, who should we contact?

Name_____*relationship*_____Phone_____

_____

Patient or patient representative signature/ Date

Staff Use Only

Initial Medical/Dental review completed by: _____ Date:_____

Doctor's Signature: _____Date:_____

Periodic Medical/Dental health reviewed by: _____Date:_____

Periodic Medical/Dental health reviewed by: _____Date:_____

Bay Area Denture and Surgery Center
Dr. Dennis Van Maren, DDS
5733 South Padre Island Dr., Ste. A
Corpus Christi, TX 78411
Phone: (361) 857-6200 Fax: (361) 857 6201

Request for Physician's Release

Dr. Dennis Van Maren, DDS will possibly be fitting this patient for dentures and/or extracting several teeth which may be surgically removed. Therefore, we need a letter of Medical Clearance for a procedure. Please indicate whether the patient needs to be pre-medicated prior to the procedure and/or any necessary precautions that would be required prior to surgery. **Oral Sedation and/or Local anesthetic will be used.**

Please Fax this form and/or a letter of medical clearance to Bay Area Denture and Surgery Center at (361) 857-6201. Thank you for your time and attention.

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Primary Care Physician: _____ Date of Last Visit: _____

Contact Phone Number: _____ Fax Number: _____

Specialty Physician: _____ Date of Last Visit: _____

Contact Phone Number: _____ Fax Number: _____

Patient's Signature/Date: _____

Thank you,
Dr. Dennis Van Maren, DDS,
Bay Area Denture and Surgery Center

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing below, I authorize Bay Area Denture and Surgery Center to use and/or disclose certain Protected Health Information about me if it is required during the course of my dental treatment. I can refuse to sign this authorization but I understand that my refusal to sign may have a negative effect on the ability of the Doctor and Staff at Bay Area Denture and Surgery Center to provide my chosen course of treatment.

Bay Area Denture and Surgery Center will not receive payment or any other compensation from a third party in exchange for disclosing my Protected Health Information and will only do so as necessary to coordinate or assist in providing my chosen course of treatment. However, when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act, HIPPA, privacy rule.

I have the right to revoke this authorization in writing except to the extent that the practice, Bay Area Denture and Surgery Center, had already acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Bay Area Denture and Surgery Center
Dr. Dennis Van Maren, DDS
5733 South Padre Island Drive, Suite A
Corpus Christi, TX 78412

_____ _____
Patient's Name (Print) Patient's Signature

_____ _____
Office Representative Signature Date