BAY AREA DENTURE and DENTAL 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)

Primary Insurance Holder Information:

Name (First, Middle Initial, Last) | Social Security Number | Phone (cell, Home, Work)

Home Address | City, State, Zip Code | Date of Birth (Mo/Day/Year)

Email Address | Dental Insurance/ Subscriber # | Employer / Contact number

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

HOW DID YOU HEAR ABOUT US?

Bay Area Denture and Surgery Center Patient Medical History

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 for implants/artificial joints, etc.?

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 / nursing

BAY AREA DENTURE AND SURGERY CENTER – MEDICAL HISTORY

I have had major surgery: YEAR _____ TYPE OF PROCEDURE _____

YEAR _____ TYPE OF PROCEDURE _____

YEAR _____ TYPE OF PROCEDURE _____

YEAR _____ TYPE OF PROCEDURE _____

Do you have any medical problems/history not listed, that you'd like to let us know about?

_____

_____

Patient Allergies: (please circle **Y** for yes or **N** for no)

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 Allergies to any medications not listed above – Which ones? _____

_____

Please list all medications you are currently taking. If you brought a list, we can put a copy of that into your records, at your request:

Medication_____ Dose _____ Frequency _____

Medication_____ Dose _____ Frequency _____

Medication_____ Dose _____ Frequency _____

Medication_____ Dose _____ Frequency _____

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____

**Should you require emergency assistance, who should we contact? MUST INCLUDE CONTACT & PHONE NUMBER

Name _____ Relationship _____ Phone _____

Bay Area
DENTURE & DENTAL

Bay Area Denture and Surgery Center

Dr. Dennis Van Maren, DDS
5733 South Padre Island Drive, Suite A
Corpus Christi, TX 78412
Phone: (361) 452-9420 FAX: (361) 452-9430

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 form 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 any 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 my no longer be protected by the Federal Health Insurance Portability and Accountability Act, HIPAA, 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

CONSENT: I have answered all health questions to the best of my knowledge _____
* INCLUDES CONSENT FOR CONFIRMATION TEXTS AND EMAILS* (PATIENT/RESPONSIBLE PARTY SIGNATURE)

_____ _____
Patient's Name (PLEASE PRINT) Patient's Signature

_____ _____
Office Representative Signature DATE

Bay Area
DENTURE & DENTAL

FINANCIAL POLICY

At Bay Area Denture and Dental Center, outstanding patient care is our primary goal and we must run a successful business to meet this goal. The financial policy outlined below was developed to help us meet those objectives. We pledge to always try and inform you of your financial obligations to the practice prior to your surgery/visits. We encourage you to ask questions if you do not understand the information below.

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Surgery Deposits

Patient deductible, co-insurance, and / or surgery deposit will be collected prior to surgery appointments being made. This includes all non-emergency cases as well.

Returned Checks

There will be a $30.00 charge for all returned checks. Once two checks have been returned, you will no longer be allowed to make any payments by check.

No Show Fee/Rescheduling Fee

There will be a $50.00 charge for missed appointments without giving a 24-hour notice of cancellation.

Family Medical Leave Act (FMLA)/Short Term Disability Forms

There is a $25.00 fee for filling out and filing these forms. We will need at least two business days to complete the forms so please plan accordingly.

Insurance Claims

Insurance is a contract between you and your insurance company. In some cases, we are NOT a party of this contract. We will bill your insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits .If your insurance company is not contracted with us, you agree tc pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us.

Collection Agency / Attorney Fees

If payment on this account is not made timely and the account is turned over to an attorney and / or collection agency, you will be responsible for paying all collection agency and / or attorney's fees associated with the collection of all balances due.

I understand and agree to comply with the above policies. I authorize to release information and assignment of benefits. By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for payment of all services rendered to me and my dependents (if applicable).

Signature: _____ **Date:** _____

Printed Name: _____

Bay Area Denture and Dental
5733 South Padre Island Drive Suite A
Corpus Christi, TX, 78412
BayAreaDenture.com
Privacy Officer Phone: 210-616-2030
Privacy Officer Email: admin@hcr-audit.com

Authorization for Use or Disclosure of Protected Health Information

I hereby voluntarily authorize the disclosure of information from my health record. I understand that I may revoke this authorization at any time in writing and submitted to the Covered Entity above, except to the extent that action has been taken in reliance on this authorization.

_____

Name of Patient

_____ _____

Signature of Patient, Parent (if patient is a minor), or Legal Representative Date

The information from my health record is to be disclosed by the Covered Entity above and provided to the following:

_____ _____

Name of Person/Organization Name of Person/Organization

_____ _____

Street Address Street Address

_____ _____

City/State/ZIP City/State/ZIP

The information to be disclosed from my health record is limited to (check):

☐ Only information related to: _____

☐ Only for the period from: _____ to _____

☐ Entire health record

Bay Area
DENTURE & DENTAL

PATIENT NAME: _____

DOB: _____

PHARMACY INFO

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE #: _____

PRIMARY PHYSICIAN

NAME: _____

PHONE #: _____

FAX #: _____

SPECIALIST INFO

NAME: _____

PHONE #: _____

FAX #: _____