PEAK DENTAL CARE
Nicholas E. Baioni DDS

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us - we will be happy to help.

Date _____ mm/dd/yy
SS# / SIN _____
Patient's Sex ❒ F ❒ M

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ mm/dd/yy Home Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone ( ) _____
Do you prefer to receive calls/messages at your: ❒ Home ❒ Work ❒ Cell Phone ❒ Email ❒ Other ( ) _____
Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated
If Student, Name of School/College _____ City _____ State _____ ❒ Full Time ❒ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone ( ) _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone ( ) _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency (not living with you) _____ Phone ( ) _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone ( ) _____
Email _____ Cell Phone ( ) _____
Driver's License # _____ Birthdate _____ mm/dd/yy Financial Institution _____
Employer _____ Work Phone ( ) _____ SS#/SIN _____
Is this Person Currently a Patient in our Office? ❒ Yes ❒ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at time of treatment.
❒ Cash ❒ Personal Check Credit Card: ❒ VISA ❒ MasterCard ❒ Discover ❒ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ mm/dd/yy SS#/SIN _____ Date Employed _____ mm/dd/yy
Name of Employer _____ Union or Local # _____ Work Phone ( ) _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
DO YOU HAVE ANY ADDITIONAL INSURANCE? ❒ Yes ❒ No

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved by financial coordinator.
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____ mm/dd/yy

Signature of patient (or parent/guardian if minor) *Date*

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MEDICAL AND DENTAL HISTORY

(to be completed by patient)

Patient's Full Name:_____ Date of Birth:_____ mm/dd/yy _____ ❒ Male ❒ Female

Patient's ❒ Current ❒ Previous Dentist(s):_____ Date of Last Dental Cleaning:_____ mm/dd/yy _____

Patient's ❒ Current ❒ Previous Physician(s):_____ Date of Last Physical Exam: _____ mm/dd/yy _____

A Please list your chief concerns for treatment: (# in order of priority):_____

_____

_____

B What or who motivated you to seek treatment and what do you expect?_____

C List all current medications including non-prescriptions:_____

_____

_____

D List all drug allergies:_____

_____

E List previous surgeries:_____

_____

_____

Please describe all "Yes" answer (use space at bottom of page if necessary)

MEDICAL	YES	NO
1 High Blood Pressure	❒	❒
2 Chest pains or heart attack	❒	❒
3 Stroke	❒	❒
4 Rheumatic Fever/Mitral Valve Prolapse	❒	❒
5 Any heart trouble, murmur or mitral valve prolapse, Angina	❒	❒
6 Prosthetic devices (heart, valve, hip, knee, etc.)	❒	❒
7 Any lung disease (T.B., emphysema, etc.)	❒	❒
8 Asthma	❒	❒
9 Allergies or hay fever	❒	❒
10 Sinus problems	❒	❒
11 Mouth breathing or excessive snoring	❒	❒
12 Ulcers or stomach problems	❒	❒
13 Diabetes	❒	❒
14 Hepatitis or liver disease (Jaundice)	❒	❒
15 Kidney or bladder disease	❒	❒
16 Thyroid trouble	❒	❒
17 Connective tissue disease	❒	❒
18 Arthritis or rheumatism	❒	❒
19 Cancer (type, date)	❒	❒
20 Serious illness not listed (list type, date)	❒	❒
21 Subject to prolonged bleeding or bruise easily	❒	❒
22 Glaucoma	❒	❒
23 Epilepsy, convulsions or seizures	❒	❒
24 Do you have HIV (AIDS)?	❒	❒
25 Are you taking any Bisphosphonates (Fosamax, Aredia, Didronel)	❒	❒
26 Pregnant or possibly pregnant (Nursing)	❒	❒
27 Using birth control medications	❒	❒
28 Use tobacco (types/how much)	❒	❒

DENTAL	YES	NO
29 Pain, popping, catching or locking in jaw joints	❒	❒
30 Clench or grind your teeth	❒	❒
31 Wake up with sore jaws	❒	❒
32 Frequent headaches (How many per week?____)	❒	❒
33 Dizziness, ringing or pain in ears	❒	❒
34 Tenderness or stiffness in the jaw, neck or back	❒	❒
35 History of TMJ (jaw joint) problems or therapy	❒	❒
36 Have you ever received instructions regarding care of your teeth or gums	❒	❒
37 Treated for or told you have gum disease	❒	❒
38 Treated or consulted for orthodontic therapy	❒	❒
39 Had head, neck or jaw injuries	❒	❒
40 Dental x-rays taken in the last year	❒	❒
41 Brush your teeth (how often)	❒	❒
42 Floss your teeth (how often)	❒	❒
43 Bad breath or unpleasant tastes in your mouth	❒	❒
44 Bleeding gums	❒	❒
45 Sore or painful teeth	❒	❒
46 Tooth sensitivity (hot, cold, sweets)	❒	❒
47 Fever blisters or mouth ulcers	❒	❒
48 Tongue thrusting habit	❒	❒
49 Place a high priority on keeping your natural teeth	❒	❒
50 Do you like your smile	❒	❒

Please expand on the above information (refer to letter or number) or add anything you feel is important: _____

_____

_____

_____

_____

The above information is accurate and complete to the best of my knowledge:

Date: _____ mm/dd/yy _____ **Patient or Guardian's Signature:** _____ **Doctor's Signature:** _____

Updated:_____ mm/dd/yy _____ P or G's Initials: _____ , _____ mm/dd/yy _____ ; _____ , _____ mm/dd/yy _____ ; _____ , _____ mm/dd/yy _____ ; _____ , _____ mm/dd/yy _____ ; _____ ;