Baywood Family Dental
Laurence R. Mester, Jr. DDS & Associates II, PA
124 Baywood Rd, Suite 100
Fayetteville, NC 28312
Phone: (910) 829-0220

Account #: _____
Today's Date: _____

PATIENT INFORMATION

Name: Birth date: Social Security #

Address: City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( ) Sex: M □ F □

Employer: Employer Phone: ( )

Email: Spouse or Parent's Name: Phone: ( )

Who to contact in case of emergency Phone: ( )

How did you hear about us?

RESPONSIBLE PARTY

Name of Person: Relation to Patient:

Address: City: State: Zip Code:

Birth date: Social Security # Email:

Employer: Work Phone#: ( )

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: Relation to Patient:

Birth date: Social Security #

Employer: Insurance Company:

ID #: Group #: Ins. Phone #:

ADDITIONAL DENTAL INFORMATION

Name of Insured: Relation to Patient:

Birth date: Social Security #

Employer: Insurance Company:

ID #: Group #: Ins. Phone #:

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

Reason for Today's Visit_____ Former Dentist_____
Date of Last Dental Exam_____ Date of Last Dental X-Rays_____
Former Dentist Contact Information_____
Please (X) a response to indicate if you have or have not had problems with any of the following:

Yes/No	Yes/No	Yes/No
□ □ Bad Breath	□ □ Grinding or Clenching	□ □ Biting Pain
□ □ Bleeding Gums	□ □ Loose or Broken Teeth	□ □ Mouth Sores or Ulcers
□ □ Clicking or Popping	□ □ Bone Loss	□ □ History of Oral Trauma
□ □ Food Impaction	□ □ Sensitivity_____	___ Dental Anxiety (scale 1-10)

□ □ Have you had a serious/difficult problem associated with any previous dental treatment? If yes, explain:
_____

MEDICAL INFORMATION

Are you in good health?_____

Has there been any change in your general health within the past year?_____
Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____
If yes, what was the illness or problem?_____
_____
_____
_____
Date of Last Physicial Exam: _____
Physician Name: _____
Phone: _____
Address: _____
Have you ever taken any drug for cancer treatment or osteoporosis? (Examples are Fosamax, Actonel, Boniva, Zometa)_____
Currently Taking/How long? _____
Do you smoke or use tobacco products? _____
How Long? _____
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
_____
If yes, what antibiotic and dose? _____
Physician Name _____
Phone: _____

ALLERGIES

Are you allergic to or have you had a reaction to?
Yes/ No

□ □ Local Anesthetics
□ □ Aspirin
□ □ Penicillin or other antibiotics
□ □ Sulfa drugs
□ □ Codeine or other narcotics
□ □ Latex
□ □ Metals

Other _____

WOMEN ONLY

Are you pregnant or nursing?_____
Are you taking birth control pills or hormonal replacement?
_____

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

Yes/No	Yes/No	Yes/No
□ □ Abnormal Bleeding	□ □ Diabetes	□ □ Pacemaker/Heart Surgery
□ □ Anemia	□ □ Epilepsy/Seizures	□ □ Psychiatric Disorders
□ □ Arthritis, Rheumatism	□ □ Fainting	□ □ Radiation Treatment
□ □ Artifical Heart Valves	□ □ Glaucoma	□ □ Respiratory Disease
□ □ Artifical Joints	□ □ Headaches	□ □ Rheumatic Fever
□ □ Asthma	□ □ Heart Murmur	□ □ Shortness of Breath
□ □ Autoimmune Disorder	□ □ Heart Problems	□ □ Stroke
□ □ Back Problems	□ □ Hepatitis A/B/C/D	□ □ Swollen Feet or Ankles
□ □ Blood Disease	□ □ High Blood Pressure	□ □ Thyroid Problems
□ □ Cancer	□ □ HIV/AIDS	□ □ Tuberculosis
□ □ Chemotherapy	□ □ Kidney Disease	□ □ Ulcer/Colitis
□ □ Circulatory Problems	□ □ Liver Disease	□ □ Venereal Disease/STDs
□ □ Cough, Persistent	□ □ Mitral Valve Prolapse	

MEDICATIONS

List medications you are currently taking: (include OTCs, herbals):

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. Our staff works as a team to provide dental expertise as well as old fashioned courtesy and compassion. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for service is due at the time services are rendered. We accept cash, debit cards and all major credit cards. A treatment plan for all dental work will be established before treatment begins. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. As a courtesy to our patients, we will file and accept payment directly from your insurance company. Since most insurance companies do not pay 100%, you are responsible for your portion at the time of your appointment. Our office will estimate your co-payment — please keep in mind — this is only an estimate.

Balances older than 30 days will be subject to additional collection fees and interest charge of 1 ½ % per month. **Charges may also be made for broken appointments and appointments cancelled without 48 hours (2 business days) advance notice.**

While the filing of insurance claims is a courtesy that we extend to our patients, please realize:

1) Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2) Insurance may pay all, some, or none of your bill. Your portion is due upfront at the time of our appointment. If your insurance does not make payment within 30 days, you will be billed for the unpaid balance.
3) Not all services are covered benefits in all contracts. Some companies arbitrarily select certain services they will not cover. Please familiarize yourself with your insurance coverage. Benefits vary.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, don't ignore bills you can't pay. Instead, contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you!

I hereby authorize Laurence R. Mester, Jr. DDS & Associates II, P.A. to submit claims and assign benefits, on my behalf to _____ Insurance Company.

I have read and understand the above.

Date _____ Signed _____

Baywood Family Dental

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other: _____
  _____

Prepared By _____

Signature _____

Date _____ _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays Other_____
❑ Spouse (provide name and phone number) _____	❑ Financial ❑ Medical
❑ Parent (provide name and phone number) _____	❑ Financial ❑ Medical
❑ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	❑ Financial ❑ Medical ❑ Appointment reminders ❑ Breach notification
❑ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing..

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____