Dr. Marjorie Baptiste DMD

PATIENT INFORMATION

Date _____ Cell Phone _____ Home Phone_____

First Name _____ Last Name _____Social Security #_____

Email _____

Residence Address

_____

Street City State Zip

Age_____Marital Status _____ Date of Birth_____

Employer_____ Occupation_____

Employer Address_____ Employer Phone_____

Name of Medical Doctor _____ Phone _____

Who may we thank for referring you to this office? _____

PRIMARY INSURANCE

Person Responsible for This Account _____

Insurance Company_____

Address (If different from patient's)

_____

Street City State Zip

Subscriber #_____Soc. Sec.#/I.D#_____Group # _____

Person to Notify in Case of Emergency

_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. Marjorie Baptiste, DMD 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 authorize the use of my signature on all insurance submissions. Dr. Marjorie Baptiste, DMD may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services rendered and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below, whichever occurs later.

_____

Signature_____Date_____

274 Madison Avenue Suite 501, New York, NY 10016

Dr. Marjorie Baptiste DMD

MEDICAL HISTORY

Circle One

.....

Yes No Are you now under the regular care of a physician?
If so, for what?

_____

When was your last physical examination?

_____

Yes No Have you had any major operations, hospitalization or illnesses?
If so, for what?

_____

Yes No Are you taking any pills, medication or drugs?
If so, please list.

_____

Yes No Have you had any unusual reaction or allergies to any medications or foods?
If so, please list.

_____

..... Have you ever had a reaction to any of the following: (PLEASE CHECK)

_____ Penicillin
_____ Sulfa drugs
_____ Codeine
_____ Aspirin
_____ Bisphosphonates
_____ Sleeping pills (Barbiturates)
_____ Tetracycline
_____ Dental anesthetic (Novocaine)
_____ Nitrous Oxide (Laughing Gas)
_____ Other

Yes No Do you smoke?
Yes No Do you drink alcohol?
Yes No Are you on a diet of any kind?
Yes No Has any member or your family had tuberculosis, diabetes, heart disease, allergies, bleeding problems or cancer?
If yes, who? _____

..... Do you have or have you ever had: (PLEASE CHECK)

_____ Rheumatic fever
_____ Heart murmur
_____ Heart attack
_____ Arteriosclerosis
_____ Diabetes
_____ Stroke
_____ Abnormal thirst
_____ Tumors or growths
_____ X-ray or radiation therapy
_____ Problems in healing
_____ Frequent headaches
_____ Mental Disorders
_____ Allergies
_____ Glaucoma
_____ Frequent fractures or dislocations
_____ Condition requiring cortisone or other steroids
_____ Painful or frequent urination
_____ Ulcers (stomach)
_____ Kidney or bladder trouble
_____ High or low blood pressure
_____ Thyroid or parathyroid disease
_____ Asthma or difficulty
_____ Anemia or other blood disorder
_____ vomiting or diarrhea
_____ Arthritis or rheumatism
_____ Painful or swollen joints
_____ Rashes or skin disorders
_____ Sinus problems
_____ Sexually related disease

Dr. Marjorie Baptiste DMD

____ Hepatitis, jaundice or other liver disease
____ Shortness of breath or chest pains upon exertion
____ Tuberculosis, emphysema or other lung disease
____ Epilepsy, seizures, convulsions or fainting spells

WOMEN ONLY:

Yes No Are you pregnant?
Yes No Are you taking birth control pills?
Yes No Do you have menstrual problems?
Yes No Have you reached menopause (Change of Life)?
Yes No Are you taking hormone replacement therapy?

DENTAL HEALTH

Yes No Do you think that your teeth are affecting your health in any way?
Have you ever had:
____ Orthodontic treatment (Braces)
____ Oral Surgery (Extraction, etc.)
____ Periodontal treatment
____ Your teeth ground or bite adjusted
____ A bite plate or other appliance
Yes No Have you noticed any loosening of your teeth?
Yes No Do you suffer from pain and/or swelling of your gums?
Yes No Do your gums often bleed when you brush your teeth?
Yes No Do you have any unpleasant odor or taste in your mouth?
Yes No Are you missing any teeth?
Reasons: Decay ( ) Gum Disease ( ) Other ( )
Yes No Do you ever had any soreness, pain, clicking or popping in the area in front of your ears?
Yes No Are you aware that recent research has suggested that infected gums may increase the dangers associated with diabetes, heart diseases, stroke, lung damage and/or (if female) delivering a premature/low-birth-weight baby?
When did you last have your teeth cleaned before this appointment?

_____
How often do you see your dentist?

_____
How often and when do you brush your teeth?

_____
Do you use: Hand tooth brush ( ) Electric toothbrush ( )
Is your toothbrush: Soft ( ) Medium ( ) Hard ( )
What else do you use to clean your teeth? (floss, toothpick, waterpick, etc.)

_____
Yes No Do you feel apprehensive when you are having a dental treatment?
Yes No Would you like to use nitrous oxide (laughing gas)?

CONSENT FOR TREATMENT

I hereby authorize Dr. _____ and whomever she may designate to perform the following procedure previously discussed:

_____
and to administer emergency care as she deems necessary. I agree to the use of local anesthetic. I have been informed of possible complications from the above dental procedures.

_____ _____
Name of Patient or Legal Guardian Date

274 Madison Avenue Suite 501, New York, NY 10016

Dr. Marjorie Baptiste DMD

DEAR PATIENT

Thank you for choosing us to be your personal Dental Care Team. We are confident that your relationship with us will be positive.Our office policy is that all dental treatment be paid for at the time of service. For your convenience, we welcome all major credit cards. In cases where your treatment is completed or your balance remains unpaid, we may charge your credit card. Kindly provide your endorsement and credit card number with the expiration date. In addition we will need the VIN number located on the back of your card above the signature.

Sincerely,
Dr. Marjorie Baptiste

CANCELLATION POLICY

We understand that emergencies happen and personal circumstances may prevent you from keeping a doctor's appointment. We ask you to show consideration by calling at least 24 hours in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor.We will dismiss the first time you fail to be present at your scheduled appointment. However, further failure to be present at your scheduled appointment can result in a charge of 50 $. This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balance.I have read and understood the cancellation policy and agree to make my best effort to abide by the terms.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

INSURANCE PAYMENT AND POLICY

- As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.
- If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may contact your insurance company for reimbursement.
- If the patient has coverage with a second insurance company, we will submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance. Benefits from the secondary coverage will be paid directly to the patient.
- Insurance is a patient's benefit designed to assist the patient in their financial obligation. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage.

274 Madison Avenue Suite 501, New York, NY 10016

- The office will collect the patient's deductible and the estimated balance after the primary insurance payment at the time of service. After the primary insurance payment is received, the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward future treatment.
- In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless a signed financial agreement has been approved. I am also responsible for any insurance claims not paid within 60 days of service.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN /DATE

CREDIT CARD AUTHORIZATION

This signature authorizes my unpaid completed dental treatment to be charged in full by:

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover
CC# _____ VIN#_____ Exp. Date _____/_____/_____
☐ VISA ☐ MasterCard ☐ American Express ☐ Discover
CC# _____ VIN#_____ Exp. Date _____/_____/_____