Dream Smile Team
CLIFTON B. BALDWIN, DDS

Name: _____ Preferred Name: _____ Date: _____

Age: _____ Birth Date: _____ Sex: _____ Driver's License Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Social Security Number: _____ Full Time Student: _____

Employer: _____ E-mail: _____

Phone (Home):_____ Work:_____ Cell:_____

Whom may we thank for referring you to our office? _____

Emergency Contact (Name and Phone Number): _____

Healthy Smile Evaluation:

Do you have crowded, or broken teeth? _____

Would you like to whiten/straighten your smile? _____

What would you like us to improve about your smile? _____

Are you currently experiencing any pain or discomfort? _____

Privacy Practices Acknowledgement:
I have received the Notice of Privacy Act and I have been provided the opportunity to review it.

Patient Signature:_____ Date:_____
Attending Doctor or Associate: _____

I hereby authorize Dr. Clifton B. Baldwin DDS PLLC to perform diagnostic procedures and dental treatment as necessary for proper dental care. I attest to the accuracy of this page.
_____ **(Initial)**

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Medical History

- Are you having pain or discomfort at this time? ☐ Yes ☐ No
- Do you feel very nervous about having dental treatment? ☐ Yes ☐ No
- Would you be interested in a simple way to whiten your teeth? ☐ Yes ☐ No
- If you could wave a magic wand and change one thing about your smile, what would it be? _____

- Have you been under the care of a physician in the past two year? ☐ Yes ☐ No

  If yes please explain: _____

- Are you taking any prescription or over the counter medications? ☐ Yes ☐ No
  If yes, please list those (including over the counter, herbal remedies and Vitamins)
  _____

Primary Care Physician Name/Phone Number_____

Pharmacy Name/ Phone Number_____

- **Circle** if you have had any adverse reactions to any of the following:

Aspirin	Erythromycin	Metals	Tetracycline
Codeine	Jewelry	Nitrous Oxide	Valium
Dental Anesthetics	Latex	Penicillin	Vicodin/Hydrocodone

List any other medication(s) or substance(s) you are allergic to
_____

- **Circle** any of the following you have had or have

Abnormal Bleeding	Cosmetic Surgery	Heart Surgery	Rheumatic Fever
Alcohol Abuse	Diabetes	Hemophilia	Seizures
Allergies	Difficulty Breathing	High Blood Pressure	Shingles
Anemia	Drug Abuse	HIV + AIDS	Sickle Cell
Disease	Angina Pectoris	Emphysema	Kidney Problems
Sinus Problems	Arthritis	Epilepsy	Liver Disease
Stroke	Artificial Heart Valve	Fainting Spells	Low Blood Pressure
Thyroid Problems	Asthma	Fever Blisters	Mitral Valve Prolapse
Tuberculosis	Blood Transfusion	Frequent Headaches	Artificial Joints/Pins
Ulcers	Cancer-Chemotherapy	Glaucoma	Hepatitis A B C
Venereal Disease	Colitis	Hay Fever	Psychiatric Problems
Yellow Jaundice	Congenital Heart Defect	Heart Attack	Radiation

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List any other disease or condition

_____

- Do you know or has anyone told you that you snore? ☐ Yes☐ No
- Do you ever wake up from sleep short of breath? ☐ Yes☐ No
- Have you ever had a sleep test? ☐ Yes☐ No
- If yes, do you wear a CPAP? ☐ Yes☐ No
- Are you on a special diet? ☐ Yes☐ No
- Do you smoke or chew tobacco? ☐ Yes☐ No

- **For women only**: Are you pregnant?☐ Yes☐ No; If yes, how many weeks? _____
- Are you on birth control?☐ Yes ☐ No

Patient or Guardian Signature _____
Date_____

Doctor or Witness Signature

_____

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Financial Agreement

Part of a successful dental treatment is a clear understanding of the costs involved and the payment terms expected. We ask you read and sign the financial agreement below prior to beginning treatment. We attempt to make each patient aware of the costs of treatment prior to beginning the treatment and will work with you to estimate what will be owed (deductibles, copayments, and non-covered expenses) after insurance. Please ask if you are at any point unsure of your financial obligation.

Spouse or parent (if someone other than yourself is financially responsible):

Name _____ **Relationship** _____ **DOB** _____
SSN_____

Address_____
City _____ **State** _____ **Zip**_____

Missed Appointments

Dr. Baldwin reserves appointment times exclusively for each patient. We are committed to being here to serve you and ask that you honor your commitment to us as well. The office reserves the right to charge a missed appointment fee for repeated short notice cancellations (less than 24 hours notice) barring sudden illness _____**(initial)**

Insurance Patients

Filing insurance is not an exact science; we estimate as closely as we can using the information given to us by your insurance carrier. There are limitations; that you the insured must ultimately be aware of. Unfortunately, it is impossible to know every restriction or alternate provision insurance carriers enforce. We file insurance as a courtesy to our patients. Please be aware it is ultimately your responsibility to be aware of your policy. If insurance has not paid within 45 day the patient will be responsible for the full balance. Any insurance benefits subsequently paid will be refunded to the patient or, if desire, held on account toward future treatment. **I hereby authorize assignment of benefits. _____ (initial)**

I have read the financial policy above. I understand and agree to abide by the terms of this policy.

Patient Signature _____**Date**_____
Attending Doctor or Witness

_____

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Dental Insurance

Insurance Subscriber _____
DOB _____
SSN _____
Employer _____

Insurance Carrier Name _____
Insurance Phone # _____

Insurance ID # _____
Group # _____

Medical Insurance
(Some of your procedures may be covered by your medical insurance; please provide us with your medical insurance)

Insurance Subscriber _____
DOB _____
SSN _____
Employer _____

Insurance Carrier Name _____
Insurance Phone # _____

Insurance ID # _____
Group # _____

Secondary Insurance Information
(If you have secondary medical or dental insurance; please provide)

Insurance Subscriber _____
DOB _____
SSN _____
Employer _____

Insurance Carrier Name _____
Insurance Phone # _____

Insurance ID # _____
Group # _____

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Dr. Clifton B. Baldwin D.D.S.
"Caring Comes First"

Thank you for making the decision to join Dr. Baldwin and his professional team through our introductory offer. We are confident that you and your family will feel at home in our office. You can expect us to deliver a premium level of care in a relaxed environment.

Our introductory offer includes:

Step 1:

- Medical/Oral history review and blood pressure reading
- Initial screening/X-Rays, Panoramic, and/or CBCT Scan
- Reading of radiographs by Dr. Baldwin
- Periodontal evaluation by a registered Dental Hygienist or Dr. Baldwin
- Documentation of existing dental conditions and diagnosis

Step 2:

- Clinical Examination by Dr. Baldwin
- Treatment Consultation - including periodontal recommendations

Before beginning your evaluation in this introductory offer, your understanding of our policy is required.

- Appointments for dental cleanings are made after step 1 and step 2 are completed and **only if the absence of periodontal disease**
  _____ **(Initial)**

Patient Signature: _____ **Date:**_____

Attending Doctor or Associate:

_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. **Please list below who you give authorization to have access to your records.**

_____
Name

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

_____ _____ _____
Signature Print Date

Required by Law: We may use or disclose your health information when we are required to do so by law.

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Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We Will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you SO, for each page, $ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information fora fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a Mitten complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the

privacy of your health information. We Will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

_____ _____ _____

Signature Print Date