**J. Mark Bayless D.M.D., Inc. and Brandi Faia D.D.S.**

**Patient's Name:** _____ **Nickname:** _____ **DOB:** _____

Father's Employer: _____ Mother's Employer: _____

Referred By: _____

**Medical History** (Please check Yes or No for each)

YES NO

☐ ☐ Patient is under the care of a physician at this time? If yes, why? Name of the physician?

_____

☐ ☐ Patient is presently taking medications? If yes, what and why?

_____

☐ ☐ Patient has an artificial heart valve(s), history of endocarditis, congenital heart conditions, or heart defect?

_____

Please check all of the following that your child has had a history of or condition related to:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Allergy to antibiotics or other drugs: _____ | ☐ | ☐ | Diabetes |
| ☐ | ☐ | ADD/ADHD | ☐ | ☐ | Ear/Throat Infection |
| ☐ | ☐ | Anemia | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Allergy to Eggs | ☐ | ☐ | GI Disease |
| ☐ | ☐ | Allergy to Latex | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Allergy to Soy | ☐ | ☐ | High/Low Blood Pressure |
| ☐ | ☐ | Allergy to other foods: _____ | ☐ | ☐ | HIV? AIDS? ARC? |
| ☐ | ☐ | Allergy to Nuts | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Anxiety Disorder | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Artificial Prosthesis, Organs, Joints, Implants | ☐ | ☐ | Mental Developmental Delay |
| ☐ | ☐ | Asperger's Syndrome | ☐ | ☐ | Physical Developmental Delay |
| ☐ | ☐ | Asthma | ☐ | ☐ | Pregnant |
| ☐ | ☐ | Autism Spectrum | ☐ | ☐ | Premedication Needed |
| ☐ | ☐ | Autoimmune Disease | ☐ | ☐ | Reactive Airway |
| ☐ | ☐ | Bleeding Disorder | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Blood Disease | ☐ | ☐ | Seizure Disorder |
| ☐ | ☐ | Breathing Difficulty (enlarged adenoids/tonsils) | ☐ | ☐ | Sensory Issues |
| ☐ | ☐ | Cancer Therapy/Immunosuppression | ☐ | ☐ | Shunt |
| ☐ | ☐ | Celiac Disease | ☐ | ☐ | Sickle Cell Disease/Trait |
| ☐ | ☐ | Cleft Lip/Palate | ☐ | ☐ | Spina Bifida |
| ☐ | ☐ | Vascular Disease | ☐ | ☐ | Tuberculosis |

Are there any health issues not listed above? _____

_____

I authorize J. Mark Bayless D.M.D., Inc. and Brandi Faia D.D.S. to examine my child in order to complete his/her own diagnosis prior to performing any dental treatment. This can include oral hygiene instruction, prophylaxis, and topical fluoride application. I understand the initial visit may require x-rays to complete a full diagnosis and treatment plan and I will be informed prior to taking any x-rays. I also understand on subsequent visits new x-rays may be required depending on my child's individual caries risk. I acknowledge that I am responsible for informing the doctor about any changes in the patient's health history prior to treatment. I understand the patient's health history information will be used as necessary for diagnosis or treatment by the doctors of J. Mark Bayless D.M.D., Inc and Brandi Faia, D.D.S. In this practice, radiographs, anesthetics, antibiotics, analgesics, sedatives, nitrous oxide-oxygen sedation, and dental restorative materials may be used. Any such treatment will be discussed with me in advance via a detailed treatment plan. **I acknowledge that I am financially responsible for all charges**. If requesting a payment plan, I authorize you to request a credit history report.

**Signature:** _____ _____ **Date:** _____

Responsible Party Relationship to Patient

For existing patients: Please initial and date after you have reviewed and updated all information. Please alert our staff if you have changed or added information.

INITIAL:_____ DATE:_____ INITIAL:_____ DATE:_____ INITIAL:_____ DATE: _____ INITIAL:_____

## Family Information:

1. **Child's Name:**_____ **Nickname:**_____ **DOB:** _____
2. **Child's Name:**_____ **Nickname:**_____ **DOB:** _____
3. **Child's Name:**_____ **Nickname:**_____ **DOB:** _____
4. **Child's Name:**_____ **Nickname:**_____ **DOB:** _____
5. **Child's Name:**_____ **Nickname:**_____ **DOB:** _____
6. **Child's Name:**_____ **Nickname:**_____ **DOB:** _____

Address (**child/children resides**):_____

City:_____ State: _____ Zip Code: _____

Home #_____

## Father's Information or Legal guardian:

If legal guardian, what is the realationship to patient:_____

Name:_____

Date of Birth:_____

Address **(if different than child's)**: _____

City:_____ State: _____ Zip Code: _____

Home #_____ Cell#_____ Work #:_____

***Email Address:*** _____

Employer: _____

Employer Address: _____

City:_____ State: _____ Zip Code: _____

Social Security #:_____

Married:_____ Single: _____ Divorced: _____ Separated: _____ Widowed_____

## *Primary Dental Insurance:*

Employee Name:_____

Date of Birth:_____

Relationship to patient:_____

Social Security #: _____

Male: _____ Female: _____

Employer Name: _____

Dental Ins. Co. Name:

_____

Effective Date: _____

Insurance Address: _____

_____

Ins. Group #:_____

Ins. Phone #:_____

## Mother's Information or Legal guardian:

If legal guardian, what is the realationship to patient:_____

Name:_____

Date of Birth:_____

Address (**if different than child's**): _____

City:_____ State: _____ Zip Code: _____

Home #_____ Cell#_____ Work #:_____

***Email Address:*** _____

Employer: _____

Employer Address: _____

City:_____ State: _____ Zip Code: _____

Social Security #:_____

Married:_____ Single: _____ Divorced: _____ Separated: _____ Widowed_____

## *Secondary Dental Insurance:*

Employee Name:_____

Date of Birth:_____

Relationship to patient:_____

Social Security #: _____

Male: _____ Female: _____

Employer Name: _____

Dental Ins. Co. Name:

_____

Effective Date: _____

Insurance Address: _____

_____

Ins. Group #:_____

Ins. Phone #:_____

# J. Mark Bayless D.M.D., Inc.
# Brandi Faia D.D.S.

## Authorization for Release of Protected Health Information (PHI)

With your written permission, we may discuss your child's dental information with a person(s) you designate. Your authorization allows dental providers and staff members to discuss your child's health history, dental treatment, finances, and appointments, (including scheduling), with a designated adult such as a family member, friend, or dental/medical practitioner.

**Patient's Name:** _____

**This patient is: □ Adult (18 years or older) □ Minor child □ Dependent adult**

□**YES.** I specifically authorize Dr. Bayless' office to disclose my information to the following individuals:

**1.** _____ _____
**Name** **Relationship to the patient**

**2.** _____ _____
**Name** **Relationship to the patient**

**3.** _____ _____
**Name** **Relationship to the patient**

**4.** _____ _____
**Name** **Relationship to the patient**

**5.** _____ _____
**Name** **Relationship to the patient**

□**NO.** I **do not** want my information shared with any individuals.

***This authorization is valid until otherwise revoked. I may cancel this consent at any time by sending a written notice to Dr. J. Mark Bayless. I understand that any discussion of information which was made before I cancelled my consent does not mean that my rights to confidentiality were breached.***

_____ _____

**Parent's Signature** **Date**

# J. Mark Bayless D.M.D., Inc.
# Brandi Faia D.D.S.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature/Date

_____

## ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____, acknowledge I have received a copy of the Dental Materials Fact Sheet from this office .

_____

Signature/Date

_____

*THE FOLLOWING IS FOR OFFICE USE:*

*We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:*

- □ *Individual refused to sign.*
- □ *Communication barriers prohibited obtaining the acknowledgement.*
- □ *An emergency situation prevented us from obtaining acknowledgement.*
- □ *Other, please specify:*_____

# J. Mark Bayless, D.M.D., Inc.
# Brandi Faia, D.M.D.

## FINANCIAL POLICIES

Thank you for choosing us to provide your dental care. We are very proud of the fact that our practice is committed to providing quality care and a comfortable dental experience for your child. An important part of the relationship that we establish with our parents is a clear understanding of our policies regarding payment for the care that we provide.

**FOR OUR PATIENTS WITH DENTAL INSURANCE:**
Our goal is to help you get the maximum benefits from your dental insurance coverage. We gladly bill your insurance company for you. However, dental insurance coverage can be very unpredictable. We do not always know how much it will pay for dental services. Because of this, any estimate that we give you for your portion of the bill that you will have to pay is only an ***estimate*** and is subject to change. **We ask that you pay your estimated portion in full at each visit.** We accept cash, checks, and credit cards (Visa, MasterCard, Discover Card, and American Express). Monthly payment plans are also available through Care Credit. If, for any reason, your insurance company does not pay in a timely manner for part, or all, of the treatment provided, you are ultimately responsible for any outstanding balance.

Diagnostic x-rays in a pediatric dental office may be needed more frequently than your insurance plan allows. It is important to understand that we provide care based upon what is necessary for your child's dental health, not what is allowed under the coverage provided by your insurance plan.

**FOR OUR PATIENTS WITHOUT DENTAL INSURANCE:**
We ask that you pay for treatment on the day that it is provided. We accept cash, checks, and credit cards (Visa, MasterCard, Discover Card, and American Express). Monthly payment plans are also available through Care Credit.

**BROKEN APPOINTMENTS:**
**A $75.00 fee will be charged for a broken appointment if we are not notified 24 hours in advance.**

I understand, and agree to follow, these financial policies.

Child's/Children's Names:_____

Parent's (Guardian's) signature: _____Date:_____