JOHN T. BAILEY, D.M.D.
917 South Wickham Rd. • West Melbourne, FL 32904
(321) 723-0938

New Patient Health Record

Patient Information

Date ______________________

Name ______________________ M / F SSN ______________________

Address ______________________ City ______________________ Zip ______________________

Home phone ______________________ Cell phone ______________________ Email ______________________

Work/day phone ______________________ Employer ______________________

Employer address ______________________

Birth date ______________________ Name of spouse ______________________ Cell ______________________

Someone (other than spouse) we could contact in case of emergency ______________________

Relationship ______________________ Their day phone ______________________ Cell ______________________

Person who is responsible for this account ______________________

Dental insurance policy holder's name? ______________________ SSN ______________________

Policy holder's employer ______________________

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

Medical Information

Are you in good health? ❑ Yes ❑ No (Females) Are you pregnant or nursing? ❑ Yes ❑ No

Name of Physician ______________________ Physician phone ______________________

Reason for last visit ______________________

Please list all medications ______________________

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Do you have or have you had any of the following?

Condition	Yes	No
Abnormal blood pressure	❑ Yes	❑ No
Allergy to any drug	❑ Yes	❑ No
Angina	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Artificial heart valve	❑ Yes	❑ No
Artificial joint	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Bacterial endocarditis	❑ Yes	❑ No
Blood thinners	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No
Canker/Cold sores	❑ Yes	❑ No
Colitis	❑ Yes	❑ No
Congenital heart lesions	❑ Yes	❑ No
Dementia	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Fainting	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Heart disease	❑ Yes	❑ No
Heart murmur	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Herpes	❑ Yes	❑ No
Immune system problem	❑ Yes	❑ No
Jaundice	❑ Yes	❑ No
Kidney disease	❑ Yes	❑ No
Latex Allergy	❑ Yes	❑ No
Mitral valve prolapse	❑ Yes	❑ No
Organ transplant	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Polio	❑ Yes	❑ No
Prolonged bleeding	❑ Yes	❑ No
Prolonged cough	❑ Yes	❑ No
Psychiatric treatment	❑ Yes	❑ No
Radiation therapy	❑ Yes	❑ No
Rheumatic fever	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Taking Aspirin daily	❑ Yes	❑ No
Thyroid disease	❑ Yes	❑ No
Tobacco use	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Venereal disease	❑ Yes	❑ No
Ulcers	❑ Yes	❑ No

Please use this space to add any other information you feel is important ______________________

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Please complete reverse side →

Dental Health

Please Circle One **1=Lowest** **5=Highest**

On a 5 point scale (5 is the highest), how important is your health?	1	2	3	4	5
On a 5 point scale, how would your rate the health of your mouth?	1	2	3	4	5
On a 5 point scale, how would your rate your smile?	1	2	3	4	5

Do you have a problem that should be addressed first? ____________________

On a 5 point scale, how effective are you with a tooth brush?	1	2	3	4	5
On a 5 point scale, how effective are you with dental floss?	1	2	3	4	5

When was the last time your teeth were cleaned? ____________________

How long do you think your existing dental work will last? ____________________

How long do you want you future dental work to last? ____________________
(5yr, 10yr, 30yr, lifetime?)

Do any of these cause tooth pain? ☐ Hot ☐ Cold ☐ Sweet ☐ Chewing

Please circle any of the following problems you feel you have:

Bleeding Gums	Food Traps
Tender or Swollen Gums	Missing Teeth
Worn Teeth	Dental Decay
Chipped or cracked Teeth	Noise in the Jaw Joint
Loose Teeth	Pain in the Jaw Joint
Sinus Problems	Headache in the temple
Teeth Clenching or Grinding	Tired Jaws
Stained or Discolored Teeth	Stained or Discolored Fillings

Please circle any of the following problems you have had in the past:

Orthodontics (Braces)	Periodontal (Gum) Therapy
Root Canal Therapy	Implant
TMJ (Jaw Joint)	Crowns or Bridges
Dentistry for cosmetic reasons	Partial or Complete Denture
Teeth Bleaching	

Are you satisfied with the appearance of your smile? ☐ Yes ☐ No

Previous Dentist ____________________ Where you satisfied? ☐ Yes ☐ No

Address ____________________

Date of last dental x-rays ____________________

Shall we obtain copies of your records ☐ Yes ☐ No

Is there anything else we should know about you or your mouth? ☐ Yes ☐ No

____

____

X ____________________ Signature ____________________ Date

John T. Bailey, D.M.D.
Family Dental Care

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Consent For Use and Disclosure of Health Information

To become part of patient record

X **Name** of Patient giving consent ______________________________

(If applicable) Name of Representative) ______________________________
(if different from patient) address of Representative______________________________
City______________________________ Zip ________________
Relationship ______________________________ Phone ________________

X **Signature** of Patient or Representative

____

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice: We reserve the right to change our privacy practices as dictated by law or prudent dental practice. You may revoke this consent at any time by providing us written notice.

Thank you, and if you have any questions about this form or the attached notice, please contact our Privacy Officer, Jane Munn.

Office use only

As privacy officer I attempted to obtain the patient's (or Representative's) signature on this acknowledgement, but did not because:

I could not communicate with the patient. ________
The Patient or Representative refused to sign. ________
The Patient was unable to sign ________
Other (describe) ________

Signature of Privacy officer or designee ______________________________

Financial Policy

Dear Patient:

We at Dr. Bailey's office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental service available today. Thank you for choosing us as your health care provider. We are committed to providing you with a positive treatment experience.
Please understand payment of your bill is considered a part of your treatment, the following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete our information and our insurance agreement forms before seeing the doctor.

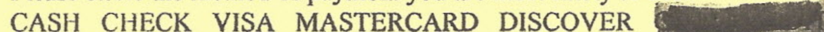
- FULL PAYMENT is due at the time of service.
- WE ACCEPT Cash, Checks, or Visa/Mastercard/Discover
- WE OFFER a financial service through Care Credit (Minimum financed - $300.00)

Minor Patients
The adult accompanying a minor and the parent (or guardian of the minor) are responsible for full payment. For unaccompanied minor, treatment cannot be provided without prior authorization by the parent or guardian.

Regarding Insurance
Usual and customary rates
Since your insurance carrier must make a profit, you can only get back in benefits what you or your employer has put into the program, minus the profit. In other words, your particular insurance program may base its dollar allowance on a fee schedule, which does not realistically coincide with current, acceptable fees.
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
We may accept assignment of insurance benefits on your second visit. However, we do require your percentage of the bill to be paid at the time of service. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will automatically be the patient's responsibility. All account balances will be subject to a finance charge of 1.5% monthly (18%APR) after 120 days. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the insurance program and/or dental insurance.
If there is a balance after 90 days, the balance will automatically be the patient's responsibility. This balance will be charged to a credit card. In the rare event that your account becomes delinquent you are responsible for all fees of collection including, but not limited to, attorney's fees and legal costs.

I,______________________________ authorize Dr. Bailey to withdraw payments from the credit card listed below. ___Visa ___Mastercard___ Discover
Credit Card Number______________________________Exp. Date: _________
Security Code______
Signature:______________________________Date:______________

Please circle the method of payment you are most likely to use:
CASH CHECK VISA MASTERCARD DISCOVER



Thank you for understanding our financial policy. Please let us know if you have questions or concerns. I have read the financial policy. I understand and agree to this financial policy.

X______________________________ ______________
Signature of Patient or Responsible Party Date