Bartholomew Paxton, DDS

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

Date_____ Whom may we thank for referring you?_____

Patient's Name_____ Age____ Birth Date_____ SS#_____

Home Address_____ City_____ ST_____ Zip Code_____

Home Phone_____ Cell_____ Email_____ Sex M/F

Employer_____ Phone_____ Work Phone_____

Occupation/Position_____ Number of years with firm_____

Emergency Contact Person_____ Relationship_____

Contact's Address_____ Contact's Phone Number_____

PERSON RESPONSIBLE FOR PAYMENT *(If different from above)*

Name_____ Relationship_____ Birth Date_____

Home Address_____ City_____ ST_____ Zip Code_____

Home Phone_____ Cell_____ Email_____ SS#_____

Employer_____ Occupation_____ Years with firm_____

Employer's Address_____ City_____ ST_____ Zip Code_____

INSURANCE INFORMATION

Person Insured_____ Relationship_____ I.D. No._____

Name of Plan_____ Claim's Phone_____ Group Number_____

Claim's Address_____ City_____ ST_____ Zip Code_____

HIPPA CONSENT

By signing this consent, you are granting permission to Dr. Bartholomew Paxton, D.D.S. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Private Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice you may obtain a copy of the revised notice by contacting our office and requesting a copy of our then current Privacy Practices. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Printed Name *Signature* *Date*

MEDICAL HISTORY

Have you been under a physician's care within the past year?_____

Major surgeries and dates:_____

Have you ever taken:

____ Phen-Fen? If YES, have you seen your physician or cardiologist for a cardiac evaluation? _____
____ Bone replacement drugs? (Fosamax, Boniva, etc.)
____ Other?

Have you ever had an unusual reaction or are you allergic to any of the following drugs:

____ Penicillin	____ Aspirin	____ Acetaminophen
____ Ibuprofen	____ Codeine	____ Barbiturates
____ Sulfa Drugs	____ Anesthetic	
____ Other_____		

Please list your current medications:_____

_____

_____

Have you ever had:

____ Rheumatic fever	____ Arthritis	____ Heart attack
____ Asthma	____ Tuberculosis	____ Kidney disease
____ Any blood disorder	____ Venereal disease	____ Immune disorders
____ Diabetes	____ Rheumatism	____ Cancer
____ Radiation treatment	____ Chemotherapy	____ Blood transfusion
____ Hepatitis A, B, C, D, other	____ Liver disease	____ Epilepsy
____ HIV / AIDS	____ High blood pressure	____ Heart problems
____ Heart murmur	____ Blood problems	____ Extended bleeding
____ Stroke		
____ Other_____		

Have you ever used or are you now using tobacco or alcohol?_____

Have you ever received counseling for use of alcohol and/or prescription drugs?_____

Women: Are you taking birth control pills?_____ Are you pregnant?_____

DENTAL HISTORY

Reason for visit: _____

Previous dentist and date of last exam?_____

Do you require antibiotic pre-medication for heart condition, artificial valve, artificial joint, etc.?_____

Do you ever suffer from severe headaches? Yes____ No____ Do you clench or grind your teeth? Yes____ No____

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. SINCE ANY CHARGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT(S).

Printed Name *Signature of Responsible Party* *Date*

OFFICE FINANCIAL POLICIES & FEDERAL TRUTH-IN-LENDING STATEMENT

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy this office will help prepare the insurance forms of our patients or assist in making collection from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by any insurance company.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form, to my insurance carrier or any related entities that require such information to be submitted.

A monthly service charge of $2.00 minimum or 2% per month (24% per year), whichever is greater, or the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding thirty (30) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be expended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged (33.33%) by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorized the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc., to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

This agreement supersedes all prior signed agreements, including any and all medication or medication/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously relation to financial arrangements or quality of care are null and void. I hereby agree to abide by the conditions outline herein.

Printed Name *Signature of Responsible Party* *Date*

CONSENT TO PROCEED

I authorize Dr. Bartholomew Paxton and/or such associates or assistants as s/he may designate to perform those procedures and may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or individual for which I have legal responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness and muscle soreness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.

Printed Name *Signature of Responsible Party* *Date*