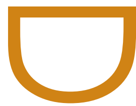

DARRYL C. BAUCUM, D.D.S.
GENERAL AND FAMILY DENTISTRY

Date ______________________

1. **Patient's Name** ______________________ Driver's License # ______________________
   Last First Middle
2. Address ______________________
   Street City State Zip Code
3. Home Phone ______________ Birth Date ______________ Social Security # ______________
4. E-mail Address ______________ Mobile Phone ______________ Work Phone ______________

5. **Person Responsible for Payment** ______________________
   Last First Middle
6. Address ______________________
   Street City State Zip Code
7. Relationship to Patient ______________________
8. Social Security # ______________________
9. Birth Date ______________________
10. Driver's License # ______________________
11. Home Phone ______________________
12. Employer ______________________
13. Work Phone ______________________

If minor, list parent's names:

Father ______________________
First Last

Mother ______________________
First Last

14. **Patient's Spouse Name** ______________________
    Last First Middle
15. Spouse's Employer ______________________
16. Occupation ______________________
17. Work Phone ______________________

DENTAL INSURANCE INFORMATION (need copy of card)

18. Insured's Name ______________________
19. Insured's Birth Date ______________________
20. Insured's Address (if different from above) ______________________
21. Insured's Social Security # ______________________
22. Insured's Employer ______________________
23. Insurance Company Name ______________________ Group Name ______________________
24. Insurance Address ______________________

EMERGENCY INFORMATION

25. Local Friend or Relative not living with you ______________________
26. Complete Address ______________________
27. Phone Number ______________________

GETTING TO KNOW YOU

28. Why did you select our office? ______________________
29. Whom may we thank for referring you? ______________________
30. Is another member of your family or relative a patient in our practice? ______________________

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistants as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

PRIVACY POLICY

I have chosen NOT to receive a copy of the privacy policy. I understand a copy is available at any time.

____

Patient's, Parent's or Guardian's Signature **Date**

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________________ Age ________

Name of Physician/and their specialty ____

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to		
❑ aspirin, ibuprofen, acetaminophen		
❑ penicillin		
❑ erythromycin		
❑ codeine		
❑ local anesthetic		
❑ fluoride		
❑ metals (gold, stainless steel)		
❑ latex		
❑ any other medications ______________		
3. heart problems	❑	❑
4. heart murmur	❑	❑
5. rheumatic fever	❑	❑
6. scarlet fever	❑	❑
7. high blood pressure	❑	❑
8. low blood pressure	❑	❑
9. a stroke	❑	❑
10. artificial prosthesis (i.e. heart valve or joints)	❑	❑
11. anemia or other blood disorder	❑	❑
12. prolonged bleeding due to a slight cut	❑	❑
13. emphysema	❑	❑
14. tuberculosis	❑	❑
15. asthma	❑	❑
16. sinus problems	❑	❑
17. kidney disease	❑	❑
18. liver disease	❑	❑
19. jaundice	❑	❑
20. thyroid or parathyroid disease	❑	❑
21. hormone deficiency	❑	❑
22. high cholesterol	❑	❑
23. diabetes	❑	❑
24. stomach or duodenal ulcer	❑	❑
25. digestive disorders	❑	❑
26. arthritis	❑	❑
27. glaucoma	❑	❑
28. contact lens	❑	❑
29. head or neck injuries	❑	❑
30. epilepsy, convulsions (seizures)	❑	❑
31. viral infections and cold sores	❑	❑
32. any lumps or swelling in the mouth	❑	❑
33. hives, rash, seasonal allergies	❑	❑
34. venereal disease	❑	❑
35. hepatitis (type___)	❑	❑
36. HIV / AIDS	❑	❑
37. tumor, abnormal growth	❑	❑
38. radiation therapy	❑	❑
39. chemotherapy	❑	❑
40. emotional problems, nervousness	❑	❑
41. psychiatric treatment	❑	❑
42. antidepressant medication	❑	❑
43. alcohol / drug dependency	❑	❑

ARE YOU:	YES	NO
44. presently being treated for any other illness	❑	❑
45. aware of any change in your general health	❑	❑
46. taking medication for osteoporosis/osteopenia	❑	❑
47. often exhausted or fatigued	❑	❑
48. subject to frequent headaches	❑	❑
49. a heavy smoker (1 pack or more a day)	❑	❑
50. considered a touchy person	❑	❑
51. often unhappy or depressed	❑	❑
52. easily upset or irritated	❑	❑
53. FEMALE: taking birth control pills	❑	❑
54. FEMALE: pregnant	❑	❑
55. MALE: prostate disorders	❑	❑

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

____

List any medications, supplements, and or vitamins taken within the last two years

DRUG	PURPOSE	DRUG	PURPOSE

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ **Date** ______________

Doctor's Signature ______________________ Date ______________

DENTAL HISTORY

How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Previous Dentist ______________________ How long have you been a patient? __________ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than cleaning) ____/____/____

I routinely see my dentist every: ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _______	❑	❑
2. Have you ever had an unfavorable dental visit?	❑	❑
3. Have you ever had complications from past dental treatment?	❑	❑
4. Have you ever had trouble getting numb or reactions to local anesthetic?	❑	❑
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	❑	❑
6. Have you had any teeth removed?	❑	❑
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?	❑	❑
8. Have you ever whitened (bleached) your teeth?	❑	❑
9. Are you self-conscious about your teeth?	❑	❑
10. Have you been disappointed with the appearance of previous dental work?	❑	❑
BITE AND JAW JOINT		
11. Do you / would you have any problems chewing gum?	❑	❑
12. Do you / would you have any problems with chewing bagels or other hard food?	❑	❑
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	❑	❑
14. Are your teeth crowding or developing spaces?	❑	❑
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	❑	❑
16. Do you have any problems with sleep or wake up with an awareness of your teeth?	❑	❑
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, or popping)	❑	❑
18. Do you have tension headaches or sore teeth?	❑	❑
19. Do you wear or have you ever worn a bite appliance?	❑	❑
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years?	❑	❑
21. Do you have a dry mouth?	❑	❑
22. Are any of your teeth sensitive to hot, cold, biting or sweets?	❑	❑
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	❑	❑
24. Do you avoid brushing any part of your mouth?	❑	❑
GUM AND BONE		
25. Have you ever been diagnosed or treated for periodontal (gum) disease?	❑	❑
26. Have you ever experienced gum recession?	❑	❑
27. Is there anyone with a history of periodontal disease in your family?	❑	❑
28. Do your gums bleed when brushing, flossing or eating?	❑	❑
29. Are your teeth becoming loose?	❑	❑
30. Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
31. Have you ever experienced a burning sensation in your mouth?	❑	❑

Patient's Signature ______________________ **Date** __________

Doctor's Signature ______________________ Date __________

DARRYL C. BAUCUM, D.D.S.
GENERAL AND FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Printed Name: ____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Business Administrator

Address: 4456 Frontier Trail, Austin, Texas 78745

Telephone: (512) 445-6666

SIGNATURE

I, ____________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ____ Date: _____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ________________________________Relationship to Patient: ______________

REVOCATION OF CONSENT

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: ________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT