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**

Eaglesoft Medical History(Baucum)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you had a recent physical exam?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, vitamins, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Men: Prostate disorders?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Erythromycin
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Fluoride	☐ Ibuprofen	☐ Acetaminophen	

Any other allergies not listed above? ◯ Yes ◯ No If yes

How would you rate your general health?

☐ Excellent
☐ Good
☐ Fair
☐ Poor

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No
Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Anxiety or Depression	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Contact lens	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Digestive disorders	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No	Hormone deficiency	◯ Yes ◯ No

Have you ever had any serious illness not listed?	◯ Yes ◯ No	If yes
Is there any current medical treatment or impending surgery that may possibly affect your dental	◯ Yes ◯ No	If yes
Do you consider yourself a touchy person?	◯ Yes ◯ No	
Do you easily get upset or irritated?	◯ Yes ◯ No	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X 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 _____

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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

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

4456 Frontier Trail
Austin, TX 78745
512.445.6666
DBaucumDDS@gmail.com
www.BaucumFamilyDentistry.com

Welcome to our office. Our goal is to provide you with the highest quality dental care and in doing so; it is our policy to make financial arrangements with you before treatment begins. Below is an explanation of our payment procedures. If you have any questions please do not hesitate to ask prior to seeing the doctor.

-We are NOT in network with any insurance companies; however we do accept PPO dental plans with out of network benefits.

-As a courtesy, we will file claims with your dental insurance company and collect co pays and/or amounts due at the time services are rendered. We **DO NOT** file medical health insurance claims.

-Insurance estimates for any office visits including but not limited to initial consultations, cleanings and treatment are **NOT guaranteed therefore any balance not paid by your insurance is your responsibility.**

-Because we are out of network, some insurance companies will only send payment to you, the policy holder; therefore we require that full payment is due on the date services are rendered. As a courtesy, we will still file the claim for you to have your insurance company reimburse you.

-We accept cash, checks, and most major credit cards. There is a $35.00 fee for returned checks. Delinquent accounts may be turned over to collections and a 30% fee is charged.

-Financing options are available for those that qualify.

-A fee may be charged for appointments cancelled or rescheduled with less than a 24 hours notice.

I have read and accept the above financial policy. I understand and agree to the terms set forth regarding my insurance and responsibility for payments.

_____ _____

Signature of Patient/Responsible Party Date

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Signature of Patient/Responsible Party Date