JEFFREY T. BAKER DDS PC
EXCELLENCE IN DENTISTRY

Patient HIPAA Acknowledgment and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA'S requirements, we are giving you a copy of our Notice of Privacy Practices, upon your request. This Notice of Privacy Practices contain the following that HIPAA requires us to disclose regarding our privacy practice

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain written consent prior to disclosing any of your information except for our disclosures in connection with:

-A defense to a claim challenging our professional competence
-A review entity's functions
-A claim for payment of fees
-A third party payer's examination of our records
-A court order as part of a criminal investigation
-An identification of a dead body
-A licensure investigation or child abuse/neglect investigation

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating you treatment.

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Name (please print) _____

Patient Signature _____ Date _____

8152 25 Mile Road, Suite C • Shelby Township, Michigan 48316
(PHONE) 586-992-9222 • (FAX) 586-992-0814 • www.smilesbybaker.com

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Patient Registration & Medical History

Thank you for choosing our office to assist you with your dental needs.

Patient Name _____ Date of Birth _____

Sex _____

If minor, name of legal guardian _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Okay to call: Yes ( ) No ( ) Okay to call: Yes ( ) No ( )

( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced ( ) Other

Email Address _____

Mailing Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Who is responsible for this account? _____ Relationship to patient _____

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

INSURANCE INFORMATION:

( ) *Not covered by dental insurance*

Your SS# _____ or Member ID# _____ Group Number _____

Dental Insurance Co. _____

Claims Address _____

Covered by another's insurance? Yes ( ) No ( ) If yes, Name of Insured _____

Insured's Dental Insurance Company _____

Claims Address _____

Insured's SS# _____ or Member ID # _____

Group Number _____ Insured's Birthday _____

Name of your primary medical physician _____

Phone number _____

See next page for Medical History.

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Medical History

Do you have, or have you had, any of the following? Please check any that apply.

( ) **Are you required to pre-medicate before any dental treatment?**

( ) Abnormal bleeding after any surgery (heavy bleeder)
( ) AIDS or HIV
( ) Arthritis
( ) Artificial joints or heart valves
( ) Asthma
( ) Back problems
( ) Blood disorders
( ) Blood transfusion
( ) Bone or joint problems
( ) Cancer/tumor
( ) Chemical dependency
( ) Chronic diarrhea
( ) Circulatory problems
( ) Diabetes TYPE 1 or TYPE 2
( ) Epilepsy or neurological disorders
( ) General allergies
( ) Hay fever or sinus trouble
( ) Headaches
( ) Heart murmur, mitral valve prolapse, heart defect
( ) Heart pacemaker
( ) Heart problems
( ) Hemophilia
( ) Hepatitis, jaundice or other liver disease
( ) Herpes or cold sores
( ) High or low blood pressure (circle one)
( ) Immunosuppressive disorders
( ) Kidney disease
( ) Nervous issues/Anxiety
( ) Psychiatric care
( ) Radiation treatment/Chemotherapy
( ) Recent weight loss
( ) Respiratory disease
( ) Rheumatic fever
( ) Special diet
( ) Stroke
( ) Swollen neck glands
( ) Thyroid problems
( ) Tuberculosis or other lung problems
( ) Ulcer
( ) Venereal disease
( ) Other: _____

CURRENT

Are you taking any of the following? If checked, history of usage:

( ) Aspirin _____
( ) Antibiotics or sulfa drugs _____
( ) Anticoagulants (blood thinners) _____
( ) Antidepressants or tranquilizers _____
( ) Cortisone or other steroids _____
( ) High blood pressure medicine _____
( ) Insulin or other diabetes drugs _____
( ) Natural supplements _____
( ) Nitroglycerin _____
( ) Osteoporosis (bone density) medicine _____
( ) Other: _____

Women:

( ) Are you pregnant or plan to become pregnant?
( ) Taking hormones or contraceptives **How long?** _____

Are you allergic to, or have you reacted adversely to, any of the following?

( ) Aspirin
( ) Barbiturates/sedatives/sleeping pills
( ) Codeine or other narcotics
( ) Latex
( ) Local anesthetics
( ) Penicillin or other antibiotics
( ) Sulfa drugs
( ) Other: _____

List all medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you smoke, vape or use tobacco? Yes ( ) No ( )

Is there anything else we should know about your medical history or any recent surgeries?

_____
_____
_____
_____
_____

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and/or processing of insurance for benefits for which I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also understand that I will be charged a finance charge of 1.5 percent if my account is over 90 days old.

Date _____ Patient Signature _____

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Dental Benefit Explanation

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume that you are as concerned as we are about maintaining your good health.

The term "dental insurance" is misleading. What is commonly known as "dental insurance" is more correctly termed dental benefits. Dental benefits are not intended to pay everything, but to assist with costs of dental treatment. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by which plan package your employer has purchased or you have purchased on your own.

As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time services are provided. However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans.

I understand and agree to these policies regarding my dental benefits.

Patient Name (please print) _____ Date _____

Patient Signature _____

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Authorization Form for Use or Disclosure of Patient Information

Patient Name: _____ Date of Birth_____

Address: _____ City: _____

State: _____ Zip: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

Patient information to be used or disclosed: (Please check which apply)

____ Appointment information ____Any information related to our dental office

____Account Information ____Other _____

____Treatment Information

I authorize Dr. Jeffrey T. Baker and staff to make this use or disclosure to the following person(s) listed below

The following person(s) may receive this patient information:

_____Relation to patient listed above_____

_____Relation to patient listed above_____

_____Relation to patient listed above_____

Patient Signature X_____ Date _____

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