BayView Dental Arts
1001 10th Avenue South
Suite 218
Naples, FL 34102

www.bayviewdentalarts.com
(239)434-5545
office@bayviewdentalarts.com

Welcome to Bayview Dental Arts

Chart #. ____
FOR OFFICE USE ONLY

Patient Name:* ____ Last * ____ First ____ MI ____ Preferred Name

Title: ____ Mr/Ms/Mrs/etc Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: * ____ SS #. ____ Prev. Visit: ____

Email Address: ____ Best time to call: ____

Phone: * ____ Home ____ Work ____ Ext ____ Mobile ____ Fax ____ Other

Address:* ____ ____

* ____ City * ____ State * ____ Zip Code

In an emergency, who should be notified? Please enter name, phone number and relationship below

* ____

Name of person, office, or other source referring you to our practice:

* ____

Dental Insurance

Dental Insurance: Please provide the front office with a copy of your dental insurance card to ensure that your claims are properly submitted.

Do you have Dental Insurance?

* ◯ Yes ◯ No

Who is the main cardhold of your policy?

* ____

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- [ ] *Pre-Med
- [ ] Alcoholism
- [ ] Allergy Ampicillin
- [ ] Allergy Aspirin
- [ ] Allergy Clindamycin
- [ ] Allergy Codeine
- [ ] Allergy Enviromental
- [ ] Allergy Latex
- [ ] Allergy Medication
- [ ] Allergy Penicillin
- [ ] Allergy Tetracycline
- [ ] Alzheimers Disease
- [ ] Anemia
- [ ] Anesthetic Sensit.
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Artificial Oxygen
- [ ] Artificial Valve
- [ ] Aspirin therapy
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Blood Disease
- [ ] Blood Thinning Med
- [ ] Cancer/ Chemotherapy
- [ ] Coumadin
- [ ] Diabetes
- [ ] Dilantin
- [ ] Emphysema
- [ ] Epilepsy/ Seizures
- [ ] Excessive Bleeding
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Transplant
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV+/ AIDS
- [ ] Kidney Disease
- [ ] Kidney Transplant
- [ ] Lichen Planus
- [ ] Liver Disease
- [ ] Melanoma
- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Nervous Disorders
- [ ] Oral Herpes
- [ ] Osteoarthritis
- [ ] Pacemaker
- [ ] Parkinson's Disease
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] SEE Medical History
- [ ] Sex. trans. disease
- [ ] Sinus Problems
- [ ] Smoker
- [ ] Stroke/ TIA
- [ ] Thyroid Disorder
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Vertigo

- [ ] Recent hospitalization (illness or injury)
- [ ] Congenital Heart Defect
- [ ] Dry-Mouth/ Xerostomia
- [ ] Oral Contraceptives/ Birth Control
- [ ] Hepatitis A
- [ ] Hepatitis C
- [ ] Head/ Neck Surgery
- [ ] Head Injury
- [ ] Acid Reflux/Gerd
- [ ] Complications with treatment
- [ ] Reactions to anesthetic
- [ ] Sensitive teeth
- [ ] Jaw Joint Popping
- [ ] Gum Disease/ Bleeding/ Recession
- [ ] Burning sensation in your mouth
- [ ] Heart Attack
- [ ] Heart By-Pass Surgery
- [ ] Chemical Dependency
- [ ] Oral Cancer
- [ ] Hepatitis B
- [ ] Sleep Apnea
- [ ] Addison's Disease
- [ ] Heart Arrythmia
- [ ] Headaches/Migraines
- [ ] Trouble getting numb
- [ ] Orthodontic treatment
- [ ] Whitened your teeth
- [ ] Clenching/ grinding of teeth
- [ ] Unpleasant taste/odor
- [ ] Snores/ wakes up during the night

If any conditions or alerts selected needs further clarification, please describe below

*

Please list all allergies and/or allergies to medications:

*

Do you take antibiotic premedication for your dental visits? If yes, please explain.

*

Please check if you are taking any of the following bone density medications

* - [ ] Fosamax - [ ] Boniva - [ ] Actonel - [ ] Reclast - [ ] Other - [ ] None

Please indicate what Blood Thinning medication you take (or type NONE):

*

List all medications (prescription and non-prescription), including regular dosages of aspirin.

*

Please list the name of your Pharmacy location and phone number:

*

Please list the name, location and phone number of Physician:

*

Please check if you currently are or previously used any of the following:

* ☐ Night Guard ☐ Retainer ☐ CPAP ☐ Snore Guard ☐ None

Is there anything that you would like to change about your smile?

*

Dental Records

Thank you for your care and skill as my dentist. I am under the professional care of Dr. Edward A. Scherder and/ or Dr. Robert C. Hedgepath and/ or Dr. Patrick Carrigan in Naples, FL. Please forward my treatment notes and radiographs to the address indicated so that their office can coordinate my dental care to:

BayView Dental Arts
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Your continued professional support and understanding with this request are greatly appreciated.

Do you have any records from a previous office that we may obtain?

* ○ Yes ○ No

Previous Dental Offices:

*

Are you seasonal? If so, what months are you in Naples?

*

Medical, Dental Insurance & Financial Policy

Your insurance can be a helpful supplement towards your dental investment depending on your plan's benefit options. Be assured that we will use all necessary resources to endure that you receive the maximum benefit under your particular plan.Patients who have medical and/or dental insurance should be aware that we are happy to submit your insurance claims to your carrier with the information you supply to us for compliance with your insurance benefits. Please note that you will be responsible for payment at the time of service.

I authorize release of information to my insurance company and assign insurance benefits payable to Bay View Dental Arts. I understand that I am financially responsible for all charges whether or not paid by insurance.
I understand that I am responsible for any collection fees or legal fees which may be incurred as a result of my failure to pay for my dental services. I further understand that Bay View Dental Arts requires a 24 hour cancellation notice. I agree to pay in full the rescheduling fee for all missed or failed appointments. I also agree to pay a fee for all returned or NSF checks.

* ☐ I have read the above conditions of treatment and payment and agree to their content.

BayView Dental Arts Notice of Privacy/ Consent Form HIPAA

Our notice of privacy practices provide information about how we may use and disclose "Protected Health Information" or "PHI" about you. You have the right to review our notice before signing, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the office.

By signing this form you consent to our use and disclosure of protected health information. You have the right to revoke the consent, in writing signed by you. However such a revocation shall not affect any disclosure we may already have made in reliance on your prior consent. Our practice provides this form to comply with the Health Insurance and Accountability Act of 1996. (HIPAA)

The patient understands that:
1. Information may be disclosed to other provided who may be involved in your countinuing care and course of treatment directly and indirectly.
2. Information may be disclosed to obtain reimbursement from your insurance company that we have on file for payment.
3. Information may be disclosed for all billing and collection activities.
4. Information may be disclosed for the authorization of any prescriptions to the pharmacy on your behalf.

Do we have your permission to talk to any of your family members? Re: Appointments, Billing and/ or Treatment.

* ○ Yes ○ No

If yes, please provide the name and phone number below.

* ____________________

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Signature: ______________________________

Date:

Response Date: