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DDS



**Baylon**  
Family Dentistry

**763-757-2914**

Raintree Professional Center  
11943 Central Avenue N.E.  
Blaine, MN 55434

## REGISTRATION

Please fill in completely.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mark appropriate box:  Child  Single  Married  Divorced  Separated

Present Employer \_\_\_\_\_ Position \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse's Full Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Position \_\_\_\_\_ Business Phone \_\_\_\_\_

If for child or teen, please list:

Father's Full Name \_\_\_\_\_

Father's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Mother's Full Name \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Children in family (name and age):

_____	_____
_____	_____
_____	_____

Name of person responsible for this account \_\_\_\_\_

Name and phone of person (other than relative) we may contact in case of emergency \_\_\_\_\_

If insured, name of dental insurance company \_\_\_\_\_

If welfare, name of agency and case number \_\_\_\_\_

Whom may we thank for this referral? \_\_\_\_\_

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

\_\_\_\_\_  
Signature (Parent or Guardian if a minor)

\_\_\_\_\_  
Date

Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

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 ans

- Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_
- Have you been hospitalized in the past year?  Yes  No If yes \_\_\_\_\_
- Have you ever been told by your doctor that you need to have antibiotics before dental treatment?  Yes  No If yes \_\_\_\_\_
- Are you taking blood thinners?  Yes  No If yes \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_
- Are you taking any other medications or drugs?  Yes  No If yes \_\_\_\_\_
- Do you use tobacco?  Yes  No

Women: Are you...

Pregnant?

Are you allergic to or do you have a sensitivity to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic
- Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes \_\_\_\_\_

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

- |   |   |   |   |
|---|---|---|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No          | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No    | Diabetes <input type="radio"/> Yes <input type="radio"/> No         |
| Hepatitis A <input type="radio"/> Yes <input type="radio"/> No                | Allergic Reaction <input type="radio"/> Yes <input type="radio"/> No    | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No         | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                     | Emphysema <input type="radio"/> Yes <input type="radio"/> No            | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No   |
| Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No       | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No     | Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No    |
| Shingles <input type="radio"/> Yes <input type="radio"/> No                   | Artificial Joint <input type="radio"/> Yes <input type="radio"/> No     | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No           | Asthma <input type="radio"/> Yes <input type="radio"/> No           |
| Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No  | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No  | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No          | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No  |
| Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No | Breathing Problems <input type="radio"/> Yes <input type="radio"/> No   | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No     | Liver Disease <input type="radio"/> Yes <input type="radio"/> No    |
| Stroke <input type="radio"/> Yes <input type="radio"/> No                     | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Cancer <input type="radio"/> Yes <input type="radio"/> No                 | Glaucoma <input type="radio"/> Yes <input type="radio"/> No         |
| Lung Disease <input type="radio"/> Yes <input type="radio"/> No               | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No      | Chemotherapy <input type="radio"/> Yes <input type="radio"/> No           | Hay Fever <input type="radio"/> Yes <input type="radio"/> No        |
| Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No      | Chest Pains <input type="radio"/> Yes <input type="radio"/> No          | Heart Attack <input type="radio"/> Yes <input type="radio"/> No           | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No     |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No  | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No         | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No     | Tumors <input type="radio"/> Yes <input type="radio"/> No           |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No  | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No      | Ulcers <input type="radio"/> Yes <input type="radio"/> No                 | Convulsions <input type="radio"/> Yes <input type="radio"/> No      |
| Heart Disease <input type="radio"/> Yes <input type="radio"/> No              | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No     |   |   |

Have you ever had any serious illness not listed  Yes  No If yes \_\_\_\_\_

Comments:

\_\_\_\_\_

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: \_\_\_\_\_

**PLANNED CARE HEALTH RECORD**

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is, of course, confidential.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**DENTAL HISTORY**

1. Former Dentist \_\_\_\_\_ Address \_\_\_\_\_
2. When did you last visit a dentist? \_\_\_\_\_ X-rays taken? Yes  No   
What was done at that time? \_\_\_\_\_  
Did you make regular visits to the dentist before then? Yes  No
3. Are you aware of a dental problem? Yes  No  Explain \_\_\_\_\_  
\_\_\_\_\_
4. What do you feel is the present condition of your mouth? \_\_\_\_\_  
\_\_\_\_\_
5. Do your gums bleed? Yes  No
6. Have you ever been told you have gum disease? Yes  No
7. Does food collect between your teeth? Yes  No
8. Are your teeth sensitive to: Sweet  Cold  Heat  Pressure
9. How often do you brush your teeth? \_\_\_\_\_
10. How often do you floss your teeth? \_\_\_\_\_
11. Are you interested in preventing further dental problems by having regular dental examinations and care?  
Yes  No
12. Anything else that would be valuable for me to know? \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

1. Name and Address of Physician \_\_\_\_\_
2. When was your last physical examination? \_\_\_\_\_
3. Are you now under the care of a physician? Yes  No   
If yes, for what reason? \_\_\_\_\_
4. List all medications or drugs and dosages that you are presently taking. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Consent for Use and Disclosure of Health Information

(For updated guidelines effective September 2013)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## 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.

**Revoke:** 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 on our Notice of Privacy Practice. Please understand that revocation of the 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 continue treating you if you revoke this Consent.

I also do hereby grant permission to Baylon & Baylon PLLC, to disclose (the patient named on this Consent) personal health information to the following personal representative(s): (spouse, sibling, parent, friend, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Information to be disclosed (please check):

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information related to treatment at this office.
- None of the above

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Policy 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 health care operations.

Signature : \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name (print) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## Baylon Family Dentistry – Baylon Pediatric Dentistry

### **New Financial Policy effective 1/1/2018**

Our doctors are dedicated to providing you with high quality dental care. In order to maintain that commitment we realize the need to collect billing in a timely manner. This credit policy is designed for that purpose.

1. New patients are required to pay for services in full at the time of their visit unless dental insurance is provided and verified. Dental claims for service provided will be filed by our office to insurance.
2. We do participate with many insurance companies but we do recommend that you verify with your insurance company in advance your eligibility and benefits with our clinic. Please understand that the amount of benefits to be derived under your policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows.
3. For your convenience, we are able to do a predetermination of benefits with your insurance company for diagnosed treatment. This is just an estimate as treatment sometimes changes.
4. Patients will be required to pay their portion of crowns, bridges, dentures and partials at the time they are seated or inserted.
5. We offer a 5% discount for patients without insurance who pay with cash or check at the time of service.
6. We offer a 10% discount for patients over 55 without insurance who pay with cash or check at the time of service.
7. We accept most major credit cards and offer Care Credit.
8. An interest rate of 1.5%/month or 18% annually will be charged on all unpaid accounts after 60 days. Please call our office if you have a balance over 60 days to make payment arrangements to avoid the automatic interest charges.

### **Office Policy**

1. The office will attempt to schedule appointments at your convenience and when time is available. Children under 5 should be seen in the morning as they tend to be more cooperative at that time.
2. Please notify our office 24 hours in advance of your scheduled appointment if you are unable to keep the appointment. Not showing for 2 appointments may result in the family being dismissed from the practice.
3. Please plan to arrive 5 minutes before your scheduled appointment. This will allow for any additional paperwork if it's needed. A parent or legal guardian must be present in the office during the initial examination and/or any restoration appointments.

I hereby authorize the administration of such diagnostic and therapeutic procedures as may be necessary for the proper dental care of myself or family members. I authorize the dentist to release any information including the diagnosis and the records of treatment rendered to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on behalf of myself and any dependants.

I have received and understand the above information.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature (Parent or Legal Guardian)

**Baylon Family Dentistry – Baylon Pediatric Dentistry**

**Informed Consent**

I hereby authorize my treating dentist, and whomever he/she may designate as his/her assistants and/or hygienists, to perform upon me those dental procedures which we have discussed, and I have accepted in the treatment plan.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

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Print name

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Signature (Parent or Guardian)

Date \_\_\_\_\_