Bayview Dentistry, P.A.
Dr. Eric S. Kneussl

WELCOME !

PATIENT HISTORY & INFORMATION

name (Mr., Mrs., Miss., Ms.) | birthdate | sex | name of spouse

address | zip code | area code/telephone

cell phone | fax number | E-mail address

Social security number | employer | employer address | business telephone

PERSON RESPONSIBLE FOR PAYMENT-PLEASE SHOW ID

Name of insurance policy holder | relationship to patient | area code/telephone

Address | occupation/employer | area code/telephone

Dental Insurance? | Name of Insurance company | Insurance telephone number

Insured SS# or Insurance ID# | Insured Birthdate | Insurance group #/Local#

Secondary Insurance Coverage? | Name of Secondary Ins. Co. | Insurance telephone number

Insured SS# or Insurance ID# | Insured Birthdate | Insurance group#/Local #

How will payment be made? | check | cash | visa/mastercard/discover

Dental History

What is the reason for this appointment? ____________________
Are there any specific dental problems we should be aware of? ____________________
Do you think you have any decay or cavities? Yes No How often do you brush? __________
Do your gums bleed easily when brushing or flossing? Yes No How often do you floss? __________
Do you suffer from chronic **bad breath or bad taste**? Yes No
Do you have any jaw joint cracking or pain? Yes No
When was your last dental appointment? ____________________
What was the purpose of your last dental appointment? ____________________
When was your last dental cleaning? __________ Name of previous dentist? ____________________
When were the last full mouth x-rays taken of your teeth? ____________________
How would you describe your dental health? excellent good fair poor
How were you referred to our office? Family Friend Insurance Internet Google
Social media __________ Doctor/Dentist Other __________

Medical information

Have you been a patient in a hospital during the past 2 years? Yes No
Have you been under the care of a physician during the past 2 years? Yes No
Have you taken any kind of medicine or drugs during the past year? Yes No
Has anyone in your family been advised of difficulties during anesthesia ? Yes No
Have you ever had any excessive bleeding requiring special treatment? Yes No

over

Patient's height_______________ Patient's weight________________

Have you ever taken phen-fen?
Do you have or have you ever been treated for?: (please circle)

Any heart problems?	Do You Smoke?	Bleeding Disorders
Heart attack	Lung/Breathing Problems	Anemia
Angina	Asthma	Hemophilia
Bypass	Bronchitis	Sickle Cell Trait/Disease
Pacemaker	Emphysema	Blood Transfusions
Stroke	Tuberculosis	Alcoholism/drug abuse
High Blood Pressure	Sinus Trouble	Nervous disorders
Low Blood Pressure	Diabetes	Psychiatric treatment
Heart Murmur*	Difficulty in healing	Epilepsy or Seizures
Mitral Valve Prolapse*	Liver problems	Thyroid Problems
Heart Valve Defect/Replacement*	Jaundice/Hepatitis A, B, C, D	Adrenal/Pituitary Problem
Rheumatic Fever*	Kidney Problems	Women: Are you pregnant?
Artificial Joint (hip/knee, etc.)*	Stomach Trouble/Ulcers	Are you nursing?
Intellectually challenged	Arthritis	Breast surgery?

Infectious disease? Yes No
HIV/AIDS Yes No Unknown
Cancer/Tumor Yes No Unknown Other Growths? Yes No
Chemotherapy/Radiation Therapy Yes No

Allergic Reaction (hives/swelling) to:

Penicillin Codeine Aspirin
Erythromycin Sulfa Local Anesthetic (Novocain) latex

Are you aware of being allergic to any other medications or substances? Please list below:

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*Do you need to take Antibiotic Premedication prior to dental appointments? Yes No Unknown
Name of Antibiotic: ____________________________

Do you have any current health problems? Yes No What? ____________________________
Are you currently being treated by a Physician? Yes No Why? ____________________________
Have you had any surgery within the past 3 years? Why? ____________________________
Physician's name, address and telephone: ____________________________
Are you presently taking **any** medications? Yes No List: ____________________________
(blood thinners, blood pressure, birth control, steroids, hormones, aspirin, ect.)________________
Preferred Pharmacy Name: ________________address________________telephone/fax_____________

CONSENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying my practice in writing.
I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities, and health care operations. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.
I have read, understand and agree to the above terms and conditions.

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PRINT NAME SIGN NAME RELATIONSHIP DATE

Medical history unchanged- 2025 sign__________________________ date: ______________
2026 sign__________________________ date: ______________

PATIENT: ______________________________

FINANCIAL AGREEMENT:

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

INSURANCE We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBLE/CO-PAYMENT We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

DELINQUENT PAYMENTS It is our policy to charge a finance fee for outstanding patient balances. In addition, all payments returned due to non-sufficient funds will be subject to a fee.

MISSED/BROKEN APPOINTMENTS Unless cancelled 24 hours in advance, our policy is to charge a fee for missed appointments. Please help us service you better by keeping scheduled appointments.

REFUND POLICY You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive. Please contact your office if you would like to request a refund.

By signing, I confirm that I have read, understand, and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

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PRINT NAME SIGNATURE RELATIONSHIP DATE