Patient Information

Patient Name_____ Date_____
Last First MI (Preferred Name)

Patient Address_____
Street Apartment#

_____
City State Zip Code

Gender_____ Marriage Status_____ Birth Date_____

Social Security # _____ Driver's License #_____ State Issued_____

Phone (Home)_____ (Work)_____ Ext:_____

(Cell)_____ Email address_____ Best Time to Call? □ Day □ Evening

Do you want to be notified about appointments by □ Email □ Text message or □ Neither

Contact in case of emergency_____
Name Phone

Additional contact not in household_____
Name Phone

Date of last dental visit_____ Reason for this Visit_____

Do you use tobacco? □ Yes □ No Type of tobacco? □ Cigarettes □ Snuff □ Other

How much tobacco used per day?_____

Have you ever had/have any of the following? Please check those that apply:

- □ AIDS
- □ Allergies_____ _____
- □ Allergy - Aspirin
- □ Allergy - Codeine
- □ Allergy-Erythromycin
- □ Allergy-Hay Fever
- □ Allergy-Latex
- □ Allergy-Penicillin
- □ Allergy-Sulfa
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Blood Disease
- □ Cancer
- □ Cold Sores/Fever Blisters
- □ Diabetes
- □ Dizziness
- □ Epilepsy
- □ Excessive Bleeding
- □ Fainting
- □ Growths
- □ Head Injuries
- □ Heart Attack
- □ Heart Conditions
- □ Heart Murmur
- □ Heart Surgery
- □ Hepatitis
- □ High Blood Pressure
- □ Hypoglycemia
- □ Jaundice
- □ Kidney Disease
- □ Liver Disease
- □ Mental Disorders
- □ Nervous Disorders
- □ Pins, Post or Screws Placed
- □ Respiratory Problems
- □ Rheumatic Fever
- □ Rheumatism
- □ Seizures
- □ Sinus Problems
- □ Surgery_____ _____
- □ Stints Placed
- □ Stomach Problems
- □ Shunt
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Tumors
- □ Ulcers

Signature of Patient/Guardian_____ Date:_____

Patient Information

Please list Medications you are currently taking:

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

Have you ever been told you have periodontal disease? ☐ Yes ☐ No

Have you ever had a deep cleaning/scaling and root planing? ☐ Yes ☐ No

- Have you ever taken Podimen, Phen Phen or Redux? If yes, how long did you take it and has a physician cleared you?_____ ☐ Yes ☐ No
- Have you ever been told to take pre-med prior to dental treatment in the past? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain:_____ ☐ Yes ☐ No
- Are you now under the care of a physician? If yes, please explain:_____ ☐ Yes ☐ No
- Name of Physician: _____
- Phone: _____
- Do you have any health problems that need further clarification? If yes, please explain: ☐ Yes ☐ No

_____

_____

- If you are female are you or do you think you may be pregnant? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answer and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Please print full name_____

Signature of Patient/Guardian_____ Date:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ Birth Date: _____

☐ Male ☐ Female ☐ Married ☐ Single

Social Security #: _____ Drivers License#: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Consent for Services

All dental services are charged directly to the patient, he/she is responsible for the patient portion the day services are rendered. The dental office is unable to offer In-House financing; we do offer Care Credit for those that qualify. As a courtesy to patients with dental insurance, we accept assignment of benefit payments from most insurance companies and will assist in collection of benefits on the patient's behalf. This will reduce the patient's immediate out-of-pocket expense. The calculation of your cost is based on the information obtained from the insurance company and is only an estimate. The patient is responsible for denied dental claims.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Dental Office

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

I authorize this person(s) access to my records_____

Harrah Family Dentistry
2405 Cappella Blvd.
Harrah, OK 73045

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