Welcome

PATIENT INFORMATION

First Name: _____M.I._____ Last Name:_____ Preferred Name:_____

Sex: ☐F ☐M Date of Birth:_____ Soc. Sec.#_____ Driver's Lic.#_____

Email: _____

Address_____ City:_____ State:_____ Zip:_____

Hm # (_____)_____-_____ Wk # (_____)_____-_____Ext._____ Cell (_____)_____-_____

Patient/Parent Employer_____

Present Position:_____ How long held:_____

Referred by: ☐Phonebook ☐Website ☐Location ☐Patient ☐Other_____

In case of emergency who should be notified? _____ Phone: _____

METHOD OF PAYMENT: Payment in full or estimated insurance co-payment is to be paid in full at each appointment.

I will pay today's charges in full by: ☐ Cash ☐ Check ☐ Credit Card ☐ Other ☐ Financing

*ALL UNPAID CHARGES WILL BE SUBJECT TO FINANCE CAHRGES, ADMINISTATION FEES AND LEGAL COSTS INCURRED DURING COLLECTIONS

Who will be responsible for the account? ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Name:_____ Soc. Sec. #_____ D.L.#_____

Hm Tel.# (_____)_____-_____Cell # (_____)_____-_____

Address:_____ City:_____ State:_____ Zip_____

Employer:_____Tel.:(_____)_____-_____

Insurance Information

Patient: ☐Married ☐Divorced ☐Widowed ☐Single ☐Child

Insurance Information

Dental Insurance- 1st Coverage

Employee Name_____

Employee Date of Birth _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Group # _____

Dental Insurance- 2nd Coverage

Employee Name_____

Employee Date of Birth _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Group # _____

Smile Evaluation

Do you have specific dental problems?	Y___N___
If yes, please explain_____	
Do you have dental examinations on routine basis	Y___N___
Do you brush and floss daily?	Y___N___
Do your gums ever bleed?	Y___N___
Do you like the appearance of your teeth?	Y___N___
Are your teeth all in alignment (straight)?	Y___N___
Do you have spaces you don't like?	Y___N___
Do you like the color of your teeth?	Y___N___
Are there old fillings or dental work you don't like looking at?	Y___N___
Do you ever have clicking/popping/discomfort in the jaw joint?	Y___N___
Do you clinch or grind your teeth?	Y___N___
Have your past dental experiences been positive?	Y___N___
Do you smoke or chew?	Y___N___

Name of previous dentist:_____

When was the last time you had a full mouth series of x-rays taken?_____

Medical information

Reason for today's office visit:

_____

Name of your Physician:

_____

Phone:_____

Have you had any illness, operation or been hospitalized in the past five years?

_____

_____

Are you taking any medication?___Y___N

Please List

_____

_____

_____

_____

Are you allergic to any medications or substances?

☐ Latex ☐Penicillin ☐Codeine ☐Sulfa

☐Aspirin ☐Acrylic ☐Metal

☐Other_____

Women

Pregnant/trying to get pregnant Y☐ N☐

Nursing Y☐ N☐

Taking oral contraceptives Y☐ N☐

Health History

Heart Trouble/Disease	Yes	No	Irregular Heart Beat	Yes	No
Angina/ Chest Pain	Yes	No	Heart Attack/ Failure	Yes	No
Congenital Heart Disorder	Yes	No	Mitral Valve Prolapse	Yes	No
Heart Murmur	Yes	No	Anemia	Yes	No
Scarlet Fever	Yes	No	Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No	Heart Surgery	Yes	No
High Blood Pressure	Yes	No	Blood Disease	Yes	No
Tuberculosis	Yes	No	Diabetes	Yes	No
Epilepsy/ Seizure	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Artificial joint, prosthesis	Yes	No
Shortness of Breath	Yes	No	Sickle Cell Disease	Yes	No
Leukemia	Yes	No	Recent Blood Transfusion	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Emphysema	Yes	No	Cancer	Yes	No
Ulcers	Yes	No	Excessive Thirst	Yes	No
Liver Disease	Yes	No	Hepatitis A (infectious)	Yes	No
Hepatitis B or C	Yes	No	Pain in Jaw Joints	Yes	No
Cortisone Medicine	Yes	No	AIDS	Yes	No
HIV Positive	Yes	No	Drug Addiction/Alcoholism	Yes	No
Kidney Problems	Yes	No	Renal Dialysis	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	Fainting or Dizziness	Yes	No
Tumors or Growths	Yes	No	Nervousness	Yes	No
Psychiatric Care	Yes	No	Alzheimer's Disease	Yes	No
Allergies (Medicines)	Yes	No	Allergies (Pollen/Dust)	Yes	No
Need Premedication?	Yes	No			

Have you ever had any serious illness not listed above?

_____

Do you wish to talk to the dentist privately about anything?

_____

I Certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____

Fees & Payment

We make every effort to keep down the cost of your dental treatment. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have dental insurance we will be glad to fill out the proper forms and file them, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.**

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____

Authorization

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date** _____

BROKEN APPOINTMENT POLICY

Patient Name _____
Date of Birth _____
Today's Date _____

Dear Patients and Parents,

Dental Care of Muskogee is a busy office. Due to the number of patients we see everyday, we ask that you kindly give a 48 hour notice if you will not be able to keep your appointment. Anything less than a 48 hour notice is considered a Broken Appointment.

We have a number of patients on our waiting list that need to be seen. We are not able to tolerate multiple Broken Appointments. When you have a Broken Appointment, your next appointment will be scheduled at the first available time slot and you will not be worked in. Unfortunately, three Broken Appointments without a 48 hour notice will result in you being dismissed as a patient from Dental Care of Muskogee, Inc.

In the case of a broken appointment a $50 per hour fee of the appointment time allocated for you will be charged for all cancellations or no shows less than 48 hours. Please notify us 48 hours prior to your appointment so we can accommodate other patients needing treatment. This charge is not covered by your insurance and must be paid prior to future appointments.

By signing below you are acknowledging you have read and you understand our policy.

_____ _____
Patient/Parent/Legal Guardian Name Date

Thank you,

Dental Care of Muskogee, Inc.

Dental Care of Muskogee, Inc.
2406 E. Shawnee Ave., Suite D
Muskogee, OK 74403
918-682-5518

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Dental Care of Muskogee's Inc. Notice of Privacy Practices.

_____
Please Print Patient Name

_____
Patient/Parent/ Guardian Signature

I authorize Dental Care of Muskogee and any of their staff to release any and all information in or regarding my health records to the following persons:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

_____
Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

- Individual Refused to Sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other:_____
  _____
  _____