

Broken Arrow Family Dentistry *** 2010 ***

Thank You for Choosing Our Practice for Your Dental Care!

PATIENT:

Name: _____ Nickname: _____
Address: _____
City, State, Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____
Cell Phone: (____) _____ Email: _____
Birthdate: _____ Social Security Number: _____ Male ___ Female ___
Employer _____ Occupation _____

RESPONSIBLE PARTY: Please complete any information that is different than that shown for the patient.

Name: _____ Relationship: _____
Address: _____
City, State, Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____
Cell Phone: (____) _____ Email: _____
Birthdate: _____ Social Security Number: _____ Male ___ Female ___
Employer _____ Occupation _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____
Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____
Cell Phone: (____) _____ Email: _____

PRIMARY Policy Holder Name: _____ Birthdate: _____
Relationship: _____ SS#: _____ ID#: _____
Employer: _____ Phone: (____) _____
Group #: _____ Group Name: _____
Insurance Co: _____ Phone: (____) _____

SECOND Policy Holder Name: _____ Birthdate: _____
Relationship: _____ SS#: _____ ID#: _____
Employer: _____ Phone: (____) _____
Group #: _____ Group Name: _____
Insurance Co: _____ Phone: (____) _____

REFERRAL: Please tell us whom we may thank, or recognize for referring you to our practice.

Name: _____ Phone Book: _____ Other: _____

I have read the BAFD Financial Policy and agree to the terms therein, including paying the estimated patient's share at the time of service. I understand that a monthly service charge of 1½ % (18% annually) may be added to any balance not paid within 30 days.

Signature of Patient or Guardian

Relationship to Patient

Date



BROKEN ARROW FAMILY DENTISTRY

Thank You For Choosing Our Office!

NAME _____ Date of Birth _____

MEDICAL HISTORY

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No |
| 3. My last physical examination was on _____ | | |
| 4. Are you now under the care of a physician? | Yes | No |
| If so, what is the condition being treated? _____ | | |
| 5. The name and address of my physician is _____ | | |
| _____ | | |
| _____ | | |
| 6. Have you had any serious illness or operation? | Yes | No |
| If so, what was the illness or operation? | | |
| 7. Have you been hospitalized or had a serious illness within the past five (5) years? | Yes | No |
| If so, what was the problem? _____ | | |
| 8. Do you have or have you had any of the following diseases or problems? | | |
| a. Damaged heart valves or artificial heart valves, including heart murmur, mitral valve prolapse | Yes | No |
| b. Congenital heart lesions | Yes | No |
| c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | Yes | No |
| 1. Do you have pain in the chest upon exertion? | Yes | No |
| 2. Are you ever short of breath after mild exercise? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| 4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? | Yes | No |
| 5. Do you have a cardiac pacemaker? | Yes | No |
| d. Allergy | Yes | No |
| e. Sinus trouble | Yes | No |
| f. Asthma or hay fever | Yes | No |
| g. Hives or a skin rash | Yes | No |
| h. Fainting spells or seizures | Yes | No |
| i. Diabetes | Yes | No |
| 1. Do you have to urinate (pass water) more than six times a day? | Yes | No |
| 2. Are you thirsty much of the time? | Yes | No |
| 3. Does your mouth frequently become dry? | Yes | No |
| j. Hepatitis, jaundice or liver disease | Yes | No |
| k. Arthritis | Yes | No |
| l. Inflammatory rheumatism (painful swollen joints) | Yes | No |
| m. Stomach ulcers | Yes | No |
| n. Kidney trouble | Yes | No |
| o. Tuberculosis | Yes | No |
| p. Do you have a persistent cough or cough up blood? | Yes | No |
| q. Low blood pressure | Yes | No |
| r. Venereal disease | Yes | No |
| s. Epilepsy | Yes | No |
| t. Psychiatric problems | Yes | No |
| u. Cancer | Yes | No |
| v. AIDS or other immunosuppressive disorders | Yes | No |
| w. Other | Yes | No |

- | | | |
|---|-----|----|
| 9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? | Yes | No |
| a. Do you bruise easily? | Yes | No |
| b. Have you ever required a blood transfusion? | Yes | No |
| If so, explain the circumstances _____ | | |
| 10. Do you have any blood disorder such as anemia? | Yes | No |
| 11. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck? | Yes | No |
| 12. Are you taking any drug or medicine? | Yes | No |
| If so, what? _____ | | |
| 13. Are you taking any of the following: | | |
| a. Antibiotics or sulfa drugs | Yes | No |
| b. Anticoagulants (blood thinners) | Yes | No |
| c. Medicine for high blood pressure | Yes | No |
| d. Cortisone (steroids) | Yes | No |
| e. Tranquilizers | Yes | No |
| f. Antihistamines | Yes | No |
| g. Aspirin | Yes | No |
| h. Insulin, tolbutamide (Orinase) or similar drug | Yes | No |
| i. Digitalis or drugs for heart trouble | Yes | No |
| j. Nitroglycerin | Yes | No |
| k. Oral contraceptive or other hormonal therapy | Yes | No |
| l. Other _____ | | |
| 14. Have you ever taken <u>any</u> prescription diet medications? | Yes | No |
| 15. Are you allergic or have you reacted adversely to: | | |
| a. Local anesthetics | Yes | No |
| b. Penicillin or other antibiotics | Yes | No |
| c. Sulfa drugs | Yes | No |
| d. Barbiturates, sedatives, or sleeping pills | Yes | No |
| e. Aspirin | Yes | No |
| f. Iodine | Yes | No |
| g. Codeine or other narcotics | Yes | No |
| h. Latex | Yes | No |
| i. Other _____ | | |
| 16. Have you had any serious trouble associated with any previous dental treatment? | Yes | No |
| If so, explain _____ | | |
| 17. Do you have any disease, condition, or problem not listed above that you think I should know about? | Yes | No |
| If so, explain _____ | | |
| 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? | Yes | No |
| 19. Are you wearing contact lenses? | Yes | No |
| 20. Have you had anything to eat or drink in the last 4 hours? | Yes | No |
| 21. Are you wearing removable dental appliances? | Yes | No |

Women

- | | | |
|--|-----|----|
| 22. Are you pregnant? | Yes | No |
| 23. Do you have any problems with your menstrual period? | Yes | No |
| 24. Are you nursing? | Yes | No |

Chief Dental Complaint

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

DATE _____

Signature of Patient

Broken Arrow Family Dentistry

Consent to Use and Disclose Dental and Medical Information

Your signature on this form is an acknowledgement that you have received a copy of our Notice of Privacy Practices and gives your consent for our office to use and disclose the protected health information for the patient(s) listed below to carry out treatment, payment activities and healthcare operations.

- **Treatment:** includes activities performed by a dentist or other healthcare providers, as well as coordinating care with third parties, consultations involving dentists, physicians or other health care providers.
- **Payment:** includes activities involved in billing matters, determining eligibility for dental benefits, seeking payment for services we have provided, and obtaining pre-certification or pre-estimation for recommended treatment.
- **Health Care Operations:** includes associated business and administrative affairs of this office.

Notice of Privacy Practices: For further details regarding the possible use or disclosure of your information, we encourage you to read our Notice of Privacy Practices before you sign this consent form. We reserve the right to change our privacy practices and issue a revised Notice of Privacy Practices. You may request a current copy from our office at any time.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice. Please understand that revocation of this consent will not affect any action we took before we received your revocation, and we may decline to provide any further treatment after a revocation has been received.

Patient Names

Include yourself and any minors or adults for whom you have legal guardianship.
If you are signing for anyone other than yourself, please note your relationship to that patient.

I authorize Broken Arrow Family Dentistry to use and disclose the dental, medical and health information for myself and the minors listed herein.

Date: _____ Signature: _____

Insurance Authorized Signature Form

I, the undersigned, expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered, or to be rendered, without obtaining my signature on each and every claim to be submitted for me and/or my dependents; and, that I will be bound by this signature as though I, the undersigned, had personally signed the particular form.

I understand that I am responsible for all costs of dental treatment and authorize payment directly to my dentist for all insurance benefits otherwise payable to me.

Date

Authorized Signature of Covered Employee

Please Print Name