2825 NW 23rd St. | Oklahoma City, OK 73107
EN Inglés (405) 942-0337
EN ESPAÑOL (405) 778-8282
Fax: (405) 947-3248

PATIENT INFORMATION

Name_____ Preferred Name_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Email_____

Birth date_____ Social Security_____ Gender: M / F Circle: Child / Single / Married / Divorced / Widowed

Employer_____ Employer City/State_____ Work Phone_____

Referred by? (Circle one) Website / Flyer / Insurance Co. / Location / Patient:_____ Other:_____

Emergency Contact_____ Phone Number_____ Relation_____

Spouse's Name_____ Birth date_____ Spouse's Cell Phone_____

DENTAL INSURANCE INFORMATION

Name of Insured_____ Birth date_____ Social Security_____

Employer_____ Insurance Co._____ ID #_____

MEDICAL HISTORY

Physician's Name_____ Phone #_____ Date of Last Visit_____

Have you had any serious illnesses or operations?_____

Have you ever had a blood transfusion? Yes or No If yes, please give approximate date(s)_____

Have you ever been told that you need to premedicate prior to dental appointments due to a medical condition?

Yes or No If Yes, what condition?_____

Women: Are you pregnant? Yes or No Due Date:_____ Are you nursing? Yes or No

Are you taking Birth Control Pills? Yes or No Are you planning on becoming pregnant soon? Yes or No

Please check if you have or have had any of the following:

__ Alcohol/Drug Abuse
__ Amoxicillin Allergy
__ Anemia
__ Anesthetic Allergy
__ Arthritis
__ Artificial Joints
__ Asthma
__ Back Problems
__ Blood Disease
__ Cancer _____
__ Chemotherapy/Radiation
__ Circulatory Problems
__ Codeine Allergy
__ Depression
__ Diabetes
__ Epilepsy
__ Fever Blisters
__ Glaucoma
__ Heart Murmur
__ Heart Valve Replacement
__ Hearing Disorder
__ Hepatitis (A - B - C)
__ High Blood Pressure
__ HIV Positive/AIDS
__ Joint/Hip Replacement
__ Kidney/Liver Disease
__ Latex Allergy
__ Mitral Valve Prolapse
__ Mouth Sores
__ Pacemaker
__ Penicillin Allergy
__ Prolonged Bleeding
__ Psychiatric Problems
__ Respiratory Disease
__ Rheumatic Fever
__ Scarlet Fever
__ STD _____
__ Shortness of Breath
__ Sleep Apnea
__ Stroke
__ Swelling of Feet/Ankles
__ Thyroid Problems
__ Tobacco Habit
__ Tuberculosis
__ Ulcer

Other conditions or allergies:
_____
_____
_____
_____
_____
_____
_____

Please list all prescribed and over-the-counter medications you are currently taking with the correlating diagnosis:

_____

_____

_____

_____

Medication Allergies:_____

DENTAL HISTORY

Previous Dentist's Name_____ Date of Last Visit:_____ Date of last full mouth x-rays:_____

How would you rate your smile 1 - 10 (1 - needs improvements and 10 - excellent)?_____

If you had a magic wand, what would you want changed about your smile?_____

_____

Is there anything keeping you from having dental treatment completed? fear / finances / pain / time / nothing

Have you ever had any serious trouble associated with previous dentistry?_____

Have you ever been diagnosed or treated for periodontal disease? (gum disease, pyorrhea, trench mouth)_____

Does dental treatment make you nervous? No / Slightly / Moderately / Extremely_____

How often do you brush your teeth?_____ Floss?_____ Toothbrush Type: Soft / Medium / Hard / Electric

Please check if you have or have had any of the following:

__ Bleeding/Sore gums
__ Unpleasant taste/bad breath
__ Clicking or popping jaw
__ Food collection between teeth
__ Biting Cheeks/Lips
__ Snoring
__ Stained teeth
__ Missing teeth
__ Partial Dentures
__ Clenching/Grinding teeth
__ Loose teeth or broken fillings
__ Sensitivity when biting
__ Sores or growth in mouth
__ Frequent blisters on lips/mouth
__ Mouth piercing
__ Ringing in ears
__ Aching or pain in teeth
__ Complete Dentures
__ Sensitivity to heat
__ Sensitivity to sweets
__ Sensitivity to cold
__ Orthodontics (braces/invisalign)
__ Difficulty opening/closing jaw
__ Pain in jaw joint or face/ear
__ Chipped or broken teeth
__ Throbbing pain
__ Dental Implants

AUTHORIZATION AND RELEASE

In accordance with the Privacy Rules of HIPPA, I am hereby giving my full consent to 23rd Street Dental to maintain my medical/dental records, transmit, forward, and/or release information about me, my health information and/or my Personal Health Information to any applicable person(s) or agencies, provided it is in my best interest and/or for the advancement or continuance of any health care services for which I am being treated. I have read and answered the above questions to the best of my knowledge and understand that I am ultimately financially responsible for all charges. By signing below I acknowledge my understanding of all terms and conditions.

_____

Patient (or guardian) Name (Printed) Patient (or Guardian) Signature Date

NEW PATIENT CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated team member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of treatment needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor or designated team member to use and disclose any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Patient Initials_____

NO-SHOW / CANCELLATION POLICY

No-show/last minute cancellations and missed appointments prevent us from providing for your dental needs. If you have a scheduling conflict, we are happy to work with you to reschedule, provided we receive at least 48 hours' notice.

Your dental health is our priority, and we are committed to offering the best care possible. However, if you have more than **3 NO SHOW OR CANCELLATIONS WITHOUT 48 HOURS' ADVANCED NOTICE**, we reserve the right to dismiss you as a patient in our office. Additionally, we are obligated to notify SoonerCare of your attendance, which may lead to termination of coverage.

By signing below, I acknowledge that I have read, fully understand, and agree to adhere to the terms outlined in this policy and accept responsibility for complying with all office policies as stated.

Patient Initials_____

FINANCIAL POLICY

Your financial responsibilities are not only important to you; they are also an essential part of your care and treatment. Should you have any questions about our financial policy, please do not hesitate to ask.

Payments are due in full at the time of service and can be made in the form of cash, check, credit card, and Care Credit.

Recommendations for your care are based on the needs of your oral health and *NOT* on your insurance benefits. However, we will strive to work with you to maximize your insurance benefits so you can have a treatment that fits within your budget.

As a courtesy to you, we accept assignment of benefit payments from most insurance companies. We are happy to assist you with your insurance; however, y**ou are responsible** for payment of all services rendered on your or your dependents' behalf. Your copay is due on the day the services are rendered.

We allow 90 days for your insurance company to make a payment. At this time all unpaid balances become your responsibility.

Patient (or guardian) Name (Printed) Patient (or Guardian) Signature Date