Coweta Family Dental

Name _____ Preferred Name _____ ☐ M ☐ F DOB _____

If child, guardian name _____ Patient/Guardian Employer _____

Home Address _____ City, State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Email_____ SSN_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Minor ☐ Widowed

Emergency Contact- Name _____ Phone # _____ Relationship _____

Whom may we thank for referring you to our office? _____

What do you want accomplished during your visit today?_____

Are you having any specific issues with your teeth?_____

What could we do to make this a positive experience for you? _____

If you could change one thing about your smile, what would it be? _____

Would you like your teeth to be whiter? _____

Are you anxious about visiting the dental office? YES / NO

How long has it been since your last dental visit? _____ Last time your teeth were cleaned? _____

Previous dentist's name_____ Phone # _____

Have you been unhappy with any previous dental care? What Happened? _____

_____

How often do you brush your teeth? _____ How often do you floss? _____

Do you consume/use sugary: ☐ Drinks ☐ Gum ☐ Candy How much/how often? _____

Do your gums bleed or hurt? YES / NO Have you ever been treated for gum disease? YES / NO

Do you worry about bad breath? .....YES NO

Are any of your teeth sensitive? YES / NO If YES, what are they sensitive to? ☐ Hot ☐ Cold ☐ Chewing ☐ Sweets

Are you missing any teeth? YES / NO If YES, how long have they been missing? _____

Have any teeth been replaced by a crown, bridge, implant, partial, or denture?.....YES NO

If yes, how old are they? _____

If partials or dentures, do you wear them regularly? .....YES NO

Are you happy with the appearance and/or fit? .....YES NO

Do you clench or grind your teeth? YES / NO Does your jaw click or pop? YES / NO

Have you experienced any pain or soreness in the muscles of your face or around your ear?.....YES NO

Do you have headaches, neck aches or shoulder aches?.....YES NO

Have you had any orthodontic work?.....YES NO

I hereby verify that the above information is complete and accurate

_____ _____

Patient or Guardian Signature Date

Coweta Family Dental

Medical History:

Are you currently under a physician's care? .....YES NO
Physician's Name_____ Phone #_____
Are you taking any medications, vitamins or supplements?..... YES NO
If yes, please list: _____

_____

Are you allergic to any medications? YES / NO If YES, please list: _____
Are you allergic to any metals?..... YES NO
Are you allergic to latex?..... YES NO
Have you ever been treated for or been told that you might have heart disease? ..... YES NO
Do you have a pacemaker or artificial heart valve implant?..... YES NO
Do you have a heart murmurs?..... YES NO
Have you ever had rheumatic fever?..... YES NO
Do you have any knee, hip, or other joint replacements?.....YES NO
If yes, when? _____
Have you ever been told that you need to take any premedication prior to dental treatment?.....YES NO
Do you have high blood pressure or take blood pressure medication?..... YES NO
Do you have low blood pressure?..... YES NO
Have you ever had radiation treatment or chemotherapy treatment?..... YES NO
Do you have inflammatory diseases, such as arthritis or rheumatism?..... YES NO
Do you have any blood disorders, such as anemia, leukemia, etc?..... YES NO
Have you ever bled excessively after being cut? YES / NO Do you take blood thinners? YES / NO
Do you have any stomach problems?.....YES NO
Do you have any kidney problems? ..... YES NO
Do you have any liver problems? ..... YES NO
Are you diabetic? (If so, type 1 or 2?).....YES NO
Do you have fainting or dizzy spells?.....YES NO
Do you have asthma?.....YES NO
Do you have epilepsy or a seizure disorder?.....YES NO
Have you tested positive for HIV/AIDS?.....YES NO
Have you tested positive for hepatitis? (If so, which type _____).....YES NO
Do you drink alcohol? YES / NO If YES, how much/how often?_____
Are you a current or former tobacco user?.....YES NO
If YES: What type?: _____ How Often?: _____ For How Long?_____
Any history of drug abuse? YES / NO If YES, please explain:_____
Are you pregnant or suspect that you may be?.....YES NO
Do you use any birth control medication?.....YES NO
Do you have osteoporosis?.....YES NO
Are you currently taking medication for osteoporosis?.....YES NO
Have you ever taken medication for osteoporosis?.....YES NO
Have you ever had a serious illness or major surgery?.....YES NO
If yes, please explain:_____
Do you have any disease, condition, or medical problem not listed?.....YES NO
If yes, please explain_____

I agree that all information written on this sheet is correct to the best of my knowledge and if any medical information changes during the course of treatment with Tulsa Family Dental I will inform the office immediately.

_____ _____

Patient or Guardian Signature Date

Coweta Family Dental

Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of privacy practices prior to signing this consent. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my children's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I Understand that my insurance carrier of my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts.

I certify that I have read and understand the above information to the best of my knowledge.

Patient/Guardian Name _____ Relationship to Patient _____

Signature _____ Date _____

Financial Agreement for Coweta Family Dental

Your dental health is our #1 concern. We do not recommend treatment based on any insurance coverage. In order to avoid any future misunderstanding, please read and sign the following:

Payment is due at the time services are rendered. For your convenience, we accept cash, Visa, MasterCard, Discover, AMEX, personal checks, and CareCredit.

Insurance benefits are determined by your employer and not your dentist. Insurance is not a guarantee of payment; insurance companies will not pay for all of your costs. Your insurance policy is a contract between you and your employer. Your insurance and payment are still your responsibility. As a courtesy, we will be glad to file your claim for you if you provide us with all required information. You will be expected to pay for services rendered at the time of service.

We reserve the right to charge and collect fees for broken appointments

(Appointments that are broken or cancelled without 24 hour advance notice will incur a charge of $25.00).

Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

If a check rendered does not clear the financial institution and is returned to us, a fee of $35.00 will be added to your account balance. Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing the treatment. We also offer outside financing through CareCredit.

We request that you be responsible for understanding your insurance benefits, coverage and limitations. You will be a responsible for any amount unpaid by your insurance plan. We will allow 30 days for your insurance company to make payment. After 30 days, all inquiries and follow up become your responsibility. Balances over 60 days may accrue a monthly finance charge and be subject to going to an outside collections agency.

I have read and understand this financial policy.

Patient/Guardian Name _____ Relationship to Patient _____

Signature _____ Date _____