Please Complete and Return to the Business Office

Personal Information

Name: Last First Middle Preferred Name

Address: Street or P.O. Box # City State Zip code | Marital Status

Work Phone: | Cell Phone: | Home Phone:

Gender | Birth Date: Mo. Day Year | Email Address:

Social Security No: (if child, responsible party's) | Driver's License No: (if child, responsible party's)

Occupation & Employer: (if child, responsible party's) | How long employed? | Address & Phone No:

Person responsible for bill: | Age: | Address: | Relationship:

Insurance Information

Insured Person's Full Name | Date of Birth

Social Security Number and ID# | Relationship to Patient | Work Phone

Insurance Company Name | Group or Union Name | Group or Local Numbers

Employer's Name | Full Address of Employer

Secondary Insurance

Insured Person's Full Name | Date of Birth

Social Security Number and ID# | Relationship to Patient | Work Phone

Insurance Company Name | Group or Union Name | Group or Local Numbers

Employer's Name | Full Address of Employer

More About You

1. Why did you select our practice? _____
2. What is your preferred method of contact? *Check all that apply.* ❒ Email ❒ Text ❒ Phone
2. Whom may we thank for referring you? _____
3. Is another member of your family or relative a patient in our practice? If yes, who? _____
4. Person to contact for emergency: _____ Phone: _____

Consent for Treatment

Consent for Treatment

1. I hereby authorize doctor or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient name) _____'s dental needs.
2. Upon such diagnosis, I authorize 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 medication 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's or designated team's use and disclosure of 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.
5. I agree to be responsible for payment for all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Signature of Responsible Party Relationship Date

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... ❒Yes ❒No
   If yes: for what reason? _____
   Please provide the name, address, and telephone number of your physician.
   _____

2. Have you been a patient in the hospital during the past five years? ..... ❒Yes ❒No
   If yes: for what reason? _____

3. Have you taken any medicine or drugs during the past five years? If yes, please list: ..... ❒Yes ❒No
   _____

4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list: ..... ❒Yes ❒No
   _____

5. Have you ever had excessive bleeding requiring special treatment? ..... ❒Yes ❒No

6. Check 'YES' for any you have experienced in the past or present. Check 'NO' for all others.

YES	NO		YES	NO		YES	NO	
❒	❒	Mitral Valve Prolapse	❒	❒	High Blood Pressure	❒	❒	Cortisone Medication
❒	❒	Heart Failure	❒	❒	Asthma	❒	❒	Arthritis / Rheumatism
❒	❒	Heart Disease or Attack	❒	❒	Emphysema	❒	❒	Cancer or Tumors
❒	❒	Family History of Cardiovascular Disease	❒	❒	Shortness of Breath	❒	❒	Chemotherapy (Cancer, Leukemia)
❒	❒	Angina Pectoris (chest pain)	❒	❒	Hay Fever	❒	❒	Thyroid Disease / Trouble
❒	❒	Rheumatic Fever	❒	❒	Allergies or Hives	❒	❒	Glaucoma
❒	❒	Congenital Heart Lesions	❒	❒	Fainting or Dizzy Spells	❒	❒	HIV Positive
❒	❒	Artificial Heart Valve	❒	❒	Epilepsy or Seizures	❒	❒	AIDS
❒	❒	Heart Pacemaker	❒	❒	Nervousness	❒	❒	Venereal Disease
❒	❒	Heart Surgery	❒	❒	Psychiatric Treatment	❒	❒	Cold Sores or Fever Blisters
❒	❒	Artificial Joint of Any Type	❒	❒	Any Form of Eating Disorder	❒	❒	Kidney Trouble
❒	❒	Diet Medication: Name_____	❒	❒	Recreational Drug Use	❒	❒	Diabetes
❒	❒	Heart Murmur	❒	❒	Drug Addiction/Alcoholism	❒	❒	Ulcers
❒	❒	Bruise Easily	❒	❒	Tuberculosis (TB)	❒	❒	Stroke
❒	❒	Blood Transfusion	❒	❒	Hepatitis: A B C (Circle)	❒	❒	Birth Control Medication
❒	❒	Hemophilia	❒	❒	Liver Disease	❒	❒	Pregnant Due Date_____
❒	❒	Sickle Cell Disease	❒	❒	Rheumatism			

Do you have any disease, condition or problem not listed? If so, please list ..... ❒Yes ❒No
_____
_____

7. Have you lost or gained more than 10 pounds in the past 12 months? ..... ❒Yes ❒No
8. Have you taken the weight loss medications fen-phen, pondimin, and/or redux? ..... ❒Yes ❒No
9. Are you taking any bisphophonates such as fosamax, actonel, aredia, and/or zometa? ..... ❒Yes ❒No

Name_____ Date_____

1. What is the reason for your visit today?_____
_____
2. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
3. What was done at your last dental visit? _____
_____
4. What is the name of your previous dentist?_____
5. How often do you have dental examinations?_____
6. How often do you brush your teeth? _____ How often do you floss? _____
7. Have you ever used or are currently using topical fluoride? .....❒Yes ❒No
8. What other dental aids do you use? (Waterpik, toothpick, etc.)_____
9. **Do you have any dental problems now?** .....❒Yes ❒No
   If yes, please describe. _____
10. Check 'YES' for any you have experienced in the past or present. Check 'NO' for all others.

YES	NO		YES	NO	
❒	❒	Hot or Cold Sensitivity	❒	❒	Snore or other sleeping disorders
❒	❒	Sweets Sensitivity	❒	❒	Use, smoke, chew tobacco
❒	❒	Biting or Chewing Sensitivity	❒	❒	Orthodontic treatment
❒	❒	Experience bad odors or bad tastes	❒	❒	Oral Surgery
❒	❒	Frequent cold sores, blisters or other lesions	❒	❒	Periodontal treatment
❒	❒	Bleeding gums	❒	❒	Your teeth ground or bite adjusted
❒	❒	Painful gums	❒	❒	Received a bite plate or mouth guard
❒	❒	Experienced gum disease	❒	❒	Clicking or popping of jaw
❒	❒	Have tooth loss	❒	❒	Pain (joint, ear, side of face)
❒	❒	Loose teeth	❒	❒	Difficulty opening / closing mouth
❒	❒	Change in your bite	❒	❒	Difficulty chewing on either side of mouth
❒	❒	Food catches between your teeth	❒	❒	Head, neck, or shoulder aches
❒	❒	Clench or grind teeth while asleep	❒	❒	Sore muscles (neck, shoulder)
❒	❒	Clench or grind teeth while awake	❒	❒	A serious injury to the mouth or head?
❒	❒	Bite lips or cheek regularly	❒		If so, please describe, including cause _____
❒	❒	Hold foreign objects with teeth (i.e. pencil)	❒		_____
❒	❒	Mouth breathe while awake or asleep	❒	❒	Experience tired jaws, especially in the morning

11. Are you satisfied with your teeth's appearance?..... .....❒Yes ❒No
12. Would you like to keep all of your teeth all of your life? .....❒Yes ❒No
13. Do you feel nervous about dental treatment? ....❒Yes ❒No
    If so, what is your biggest concern?_____,,,.....❒Yes ❒No
14. Have you ever had an upsetting dental experience? .....❒Yes ❒No
    Please describe. _____
15. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
16. Is there anything else you would like us to know? Please describe._____
    _____
17. Have you ever had any teeth removed? _____
18. How long have these teeth been missing? _____
19. Have these teeth been replaced? _____
    How? Bridge_____ Partial_____ Denture_____ Implants_____

Name_____ Date_____

SMILE EVALUATION

1. Do you like the way your teeth look? Yes ☐ No ☐
Explain: _____

2. Are you happy with the color of your teeth? Yes ☐ No ☐
Explain: _____

3. Would you like for your teeth to be whiter? Yes ☐ No ☐
Explain: _____

4. Would you like your teeth to be straighter? Yes ☐ No ☐
Explain: _____

5. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐
If so, where? _____

6. Would you like your teeth to be longer? Yes ☐ No ☐
If so, Upper, Lower, Both? _____

7. Do you like the shape of your teeth? Yes ☐ No ☐
Explain: _____

8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐
Explain: _____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
Yes ☐ No ☐
Explain: _____

10. If you could change anything about your smile, what would you change?
_____

Name_____ Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make any significant changes in our privacy practice, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For Example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of the healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/ dental supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health and safety OR the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information or inmate or patient under certain circumstances.

Appointments reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, emails, SMS text messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make your request in writing to obtain access to your health information. You may obtain a form to request acess by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for the expenses such as copies and staff time. If you request copies, we will charge you **.25 cents for each page**, **$0.00/ hour** for staff time to locate and copy health information, and postage if you want copies mailed to you. If you request an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this information more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or locations and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), then you are entitles to receive this form in hard copy, written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or if you have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy or your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Rebecca Thompson

Telephone: (405) 728-7171 Fax: (405) 720-1997

Email: Contact@SimonDentalOKC.com

Address: 8001 N. MacArthur Blvd., Oklahoma City, OK 73132

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

FINANCIAL POLICY

This form is an effort to clarify our policy regarding dental insurance and financial arrangements made through our office. Please read and sign this form. If you have any questions, feel free to talk with our Financial Manager before you leave today. This form will be kept in your chart for your patient records.

As your dental provider we try to be aware of the most current benefits with each insurance policy, however, benefits change without our knowledge. Since your insurance is a contract between you and your carrier, not our office, please makes us aware of any changes in your insurance benefits or plan before your appointment. Treatment the doctor recommends is not dictated by insurance companies. We diagnose and treat our patients as we would want our own families to be treated.

As a courtesy to our patients, we will continue to file your insurance and accept assignment of benefits. Since your policy is a contract between you and your insurance company, we ask your assistance in being financially responsible for non-covered services and/or services not paid by insurance thirty days (30) after service. Your **estimated** copayment is due at the time of service unless prior arrangements have been made with our Financial Manager.

We want our patients to be able to comfortably afford dental care. We will gladly discuss our financial policies with you before treatment. Remember, the estimated amount your insurance will cover, by our office, Is only an **estimate**.

I understand the above financial policy with the office of Rahill and Simon, LLC.

Patient Signature Date

Parent / Legal Guardian Date