Patient Information (Confidential) *Please complete this form in its entirety

Name _____

Address_____ City_____ State_____ Zip_____

Social Security _____ Birth Date_____ Cell Phone _____

Employer _____ Work Phone_____ Home Phone_____

Email _____

Circle Appropriate Option: Minor Single Married Divorced Widowed Separated

Male Female

College student: Full-time Part-time Not applicable

Employed: Full-time Part-time Not applicable

How did you hear about us?

Walk In Insurance Referral Internet Search Dentist Referral* Friend/Family Referral* Yellow Pages

*Name _____

Person to contact in case of an emergency _____

Phone_____ Relationship to patient _____

Insurance

Insurance Company _____ ID Number _____

Subscriber Name_____ Subscriber Social Security_____

Subscriber Birth Date _____Subscriber Address_____

*Please provide your insurance card for the front office staff**

Secondary insurance? _____

Responsible Party (If self, leave blank)

Person responsible for this patient_____ Relationship to patient_____

Address_____ City_____ State_____ Zip_____

Driver's License Number_____ Social Security _____

Phone_____ Birth Date_____ Employer_____

Signature of Patient, Parent or Guardian: _____Date: _____

1526 West 8th Avenue
Stillwater, OK 74074
Office (405)377-7323 Fax (405)372-1576
www.RoseRockFamilyDentistry.com

DENTAL HISTORY

Patient's name _____Birth date_____

Reason for this visit_____

When was your last dental visit _____

What was done then_____

How often did you visit the dentist before then _____

Previous dentist (name and location) _____

Have you had a complete series of dental films (x-rays) taken- ❑ Yes ❑ No

When & Where_____

How often do you brush your teeth _____

How often do you floss your teeth _____

Is your drinking water fluoridated YES _____ NO ____

Do your gums bleed while brushing or flossing ❑ Yes ❑ No
Are your teeth sensitive to hot/cold liquids/foods ❑ Yes ❑ No
Are your teeth sensitive to sweet/sour liquids/foods ❑Yes ❑ No
Do any of your teeth feel painful ❑ Yes ❑ No
Do you have any sores or lumps in or near your mouth ❑ Yes ❑ No
Have you had any head, neck, or jaw injuries ❑ Yes ❑ No
Have you experienced any of the following problems?
- Clicking in your jaw ❑ Yes ❑ No
- Pain (joint, ear, side of face) ❑ Yes ❑ No
- Difficulty in opening or closing your jaw ❑ Yes ❑ No
- Difficulty in chewing ❑ Yes ❑ No

Do you have frequent headaches ❑ Yes ❑ No
Do you clench or grind your teeth ❑ Yes ❑ No
Do you bite your lips or cheeks frequently ❑ Yes ❑ No
Have you noticed any loosening of your teeth ❑ Yes ❑ No
Does food tend to become caught between your teeth ❑ Yes ❑ No
Have you ever had periodontal treatment (gums) ❑ Yes ❑ No
Have you ever worn a bite plate or other appliance ❑ Yes ❑ No
Have you had any difficult extractions in the past ❑ Yes ❑ No
Have you had any prolonged bleeding following an extraction ❑ Yes ❑ No
Do you wear dentures or partials ❑ Yes ❑ No
If yes, give the date they were placed _____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums ❑ Yes ❑ No

If you could change <u>anything</u> about your smile, what would you change?

_____

AUTHORIZATION AND RELEASE: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

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Medical History

Patient's Name: _____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now?	☐ Yes	☐ No	If yes:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes:
Are you on a special diet?	☐ Yes	☐ No	If yes:
Do you use tobacco?	☐ Yes	☐ No	If yes:

Women: Are you?

☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other Allergies: _____

Do you use controlled substances? ☐ Yes ☐ No

If yes: _____

Do you have, or have had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Problems	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease ☐ Yellow Jaundice

Have you ever had any serious illness not listed? ☐ Yes ☐ No *If Yes*: _____

Signature of Patient or Guardian: _____ **Date:** _____

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Financial Policy

Patient's Name _____

Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information & Insurance form before seeing the doctor.

REGARDING PAYMENT:

We fully believe dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations we do provide payment options.

PAYMENT OPTIONS:

- We accept: Cash, Check, and most major Credit Cards – for the portion that insurance does not cover.
- Care Credit – Our office team will review the details for this third-party payment option upon request. ****Payment for service is due at the time services are rendered unless prior arrangements have been made with the billing receptionist and approved by the doctor***.

REGARDING INSURANCE: (PLEASE READ AND INITIAL)

Your insurance policy is a contract between you and your insurance company. **We are not a party to that contract.** In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. All accounts with a balance over 60 days may be subject to an interest charge of 1.5% a month. **Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy.** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates. Your complete insurance information must be presented at the time services are provided. **Insurance claims cannot be backdated**. Most benefits will be verified before your insurance can be billed. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

All insurance co-pays and deductibles must be paid at the time of service. **INITIAL _____**

FAMILY ACCOUNTS: All patients 18 and older must fill out and sign a Financial Policy. The Guarantor of family account must sign a Financial Policy. **Anyone 18 and older will ultimately be personally responsible for themselves.**

DIVORCED PARENTS: (PLEASE READ AND INITIAL) Co-pays for any services for dependents are due on date of service by the **accompanying parent.** Treatment plans are provided prior to appointments with estimated co-pays. **If needed, a prior arrangement with a parent needs to be taken care of before the child's appointment.** Copays need to be paid in full at or before the child's appointment.

INITIAL_____

Missed/Canceled Appointments: (PLEASE READ AND INITIAL)

Unless cancelled **24 hours** in advance, our policy is as follows for missed appointments:

Professional Cleaning Appointment	***$25***	**INITIAL_____**
Restorative Treatment Appointment	***$50***	**INITIAL_____**
Appointments scheduled for 2 hours or longer	***$75***	**INITIAL_____**

I understand this financial policy and that I am responsible to pay all fees associated with my treatment. I understand that estimates given to me are **ONLY ESTIMATES** and I am still responsible for any balance not covered by my insurance company. We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Signature of Patient, Parent or Guardian: _____Date: _____

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Patient HIPAA Consent Form

Patient's Name_____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

What this is all about:

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, text message or U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to your PHI and must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with the state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.
9. You have the right to request restrictions in the use of your Protected Health Information and to request to change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

Please list individuals who we are able to release medical information to:

_____ _____

_____ _____

Signature of Patient or Guardian: _____Date: _____

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