OAK GROVE FAMILY DENTISTRY

Welcome! Thank you for choosing our office to meet your oral health needs.

PATIENT INFORMATION Date: ____________________

Name: ____
(Last) (First) (MI) (Preferred)

Sex: _____ Marital Status: _________ Age: ______ DOB: __________________SSN: ________________________

Address: ____
(Street) (City/St) (Zip)

E-mail Address:____

Home Phone: ___________________ Cell Phone: __________________ Work Phone: _____________________

Patient's Employer: ____________________________ Occupation: _______________________________________

Spouse's Name: _____________________________DOB:_______________SSN: __________________________

PLEASE COMPLETE SECTION BELOW IF PATIENT IS A MINOR OR STUDENT

Father's Name: ______________________________ DOB: _________________ SSN: _______________________

Home Address: ________________________________ City/State/Zip: ______________________________________

Home Phone: ___________________ Cell Phone: ____________________ Work Phone: _____________________

Mother's Name: ______________________________ DOB: _________________ SSN: ________________________

Home Address: ________________________________ City/State/Zip: ______________________________________

Home Phone: ___________________ Cell Phone: ____________________ Work Phone: _____________________

EMERGENCY CONTACT INFORMATION *(Name of person not living with you)*

Name: __________________________Relationship to patient: __________________Phone: ____________________

DENTAL INSURANCE

Primary **Dental** Ins Co.: ______________________ Secondary **Dental** Ins Co.: _____________________________

Policy #: __________________________________ Policy #: ____

Policy Holder's Name: _______________________ Policy Holder's Name: ________________________________

Policy Holder's Employer: ____________________ Policy Holder's Employer: ____________________________

Policy Holder's SSN: ________________________ Policy Holder's SSN: _________________________________

Policy Holder's DOB: ________________________ Policy Holder's DOB: _________________________________

Relationship to Patient: _______________________ Relationship to Patient: _______________________________

NAME:____ DATE_____________________

Last First MI

Medical History

Please check any allergies that may apply:

- ❑ Clindamycin
- ❑ Codeine
- ❑ Flavorings
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Pine nuts/nuts
- ❑ Sulfa/Bactrim

Other: ________________________________

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❑ Y ❑ N Are you under any medical treatment now? ____

❑ Y ❑ N Are you currently seeing a cardiologist for anything? Whom? _______________________________

❑ Y ❑ N Are you currently on any blood thinners? Name of drug? ___________________________________

❑ Y ❑ N Do you have or have you had cancer? Type? ____

❑ Y ❑ N Have you had joint replacement therapy? Knee/Hip/Shoulder? _____________________________

❑ Y ❑ N Please give the name of the Surgeon who performed your joint replacement as well as the date that the replacement was performed. ____

❑ Y ❑ N Have you ever been told to take antibiotics before a dental appointment? ________________________

❑ Y ❑ N Do you have problems with your thyroid gland? ____

❑ Y ❑ N Do you take medication for emotional problems? ____

❑ Y ❑ N Do you have problems with prolonged bleeding after extractions or surgery? _____________________

❑ Y ❑ N Are you in good health at this time? ____

❑ Y ❑ N Do you take Bisphosphonates? (examples: Boniva, Fosamax, Actonel, Reclast) __________________

❑ Y ❑ N Are you now or do you have any reason to believe that you are positive for HIV virus (AIDS)?

❑ Y ❑ N Women, are you Pregnant? Months? _________ Doctor?____________________________________

❑ Y ❑ N Women, are you breastfeeding? ____

Check any of the following that you now have or have ever had:

- ❑ Acid Reflux
- ❑ ADHD
- ❑ Anemia
- ❑ Angina
- ❑ Anorexia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Autism/Asperger’s
- ❑ Bleeding Disorder
- ❑ Bulimia
- ❑ Cerebral Palsy
- ❑ Chemical Dependency
- ❑ Convulsions
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness/Fainting Spells
- ❑ Epilepsy/Seizures
- ❑ Frequent Headaches
- ❑ Hearing Problems
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Problems
- ❑ Low Blood Pressure
- ❑ Mononucleosis
- ❑ MVP
- ❑ Pacemaker
- ❑ Psychiatric Treatment
- ❑ Radiation/Chemo
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ STD
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ OTHER:___________________

Please list any medications you are currently taking: ____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient’s dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

____ _______________

Signature of Patient/Legal Guardian **Date**

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. If you would like more information about our payment options, please speak to a member of our office staff.

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service, you will be responsible for any collection charges.

Please Initial:

_____________The parent or guardian who brings a child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be between the divorced parents. We will not intervene.

Do You Have Insurance?

- Oak Grove Family Dentitstry is not a participating provider with any dental insurance companies.
- We must emphasize that as your dental care provider our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all of your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. In the event that an insurance company will not send payment directly to us, payment in full is due at the time services are rendered.
- We ask that you pay the deductible and co-payment, which is the <u>estimated</u> amount, not covered by your insurance company, by cash, check, credit card or patient financing at the time we provide the service.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over your claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance and/or collection charge will be added to any overdue balance. By signing below, your are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call and/or text message from us, and/or outgoing call to us, to or from any such number, without reimbursement from us.

Please note that electronic communications inititated by Oak Grove Family Dentistry will not be used for solicitation.

By checking the boxes below, I choose to opt out of the following electronic communications:

❒ I DO NOT wish to receive email reminders.

❒ I DO NOT wish to receive text message reminders.

____ ___________________

Patient Signature (Guardian) **Date**

Oak Grove Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICEs

****You May Refuse to Sign This Acknowledgement****

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

____
(Please Print Name)

____
(Signature)

____
(Date)

Please list below the names of any individuals that you authorize Oak Grove Family Dentistry to speak with regarding your dental health and/or account information.

____

____

For Office Use Only

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

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

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