Broken Arrow Family Dentistry

Thank You for Choosing Our Practice for Your Dental Care!

PATIENT:

Name: ______________________________ Nickname: ______________

Address: ____

City, State, Zip: ____

Home Phone: (_____) ______________ Work Phone: (_____) ______________ Ext: ______________

Cell Phone: (_____) ______________ Email: ________________________________

Birthdate: ____________ Social Security Number: ______________ Male ___ Female ___

Employer ______________________________ Occupation ______________________________

RESPONSIBLE PARTY: Please complete any information that is different than that shown for the patient.

Name: ______________________________ Relationship: ______________

Address: ____

City, State, Zip: ____

Home Phone: (_____) ______________ Work Phone: (_____) ______________ Ext: ______________

Cell Phone: (_____) ______________ Email: ________________________________

Birthdate: ____________ Social Security Number: ______________ Male ___ Female ___

Employer ______________________________ Occupation ______________________________

EMERGENCY CONTACT:

Name: ______________________________ Relationship: ______________

Home Phone: (_____) ______________ Work Phone: (_____) ______________ Ext: ______________

Cell Phone: (_____) ______________ Email: ________________________________

PRIMARY Policy Holder Name: ______________________________ Birthdate: ______________

Relationship: ______________ SS#: ______________ ID#: ______________

Employer: ______________________________ Phone: (_____) ______________

Group #: ______________ Group Name: ______________________________

Insurance Co: ______________________________ Phone: (_____) ______________

SECOND Policy Holder Name: ______________________________ Birthdate: ______________

Relationship: ______________ SS#: ______________ ID#: ______________

Employer: ______________________________ Phone: (_____) ______________

Group #: ______________ Group Name: ______________________________

Insurance Co: ______________________________ Phone: (_____) ______________

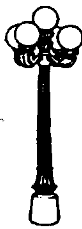
REFERRAL: Please tell us whom we may thank, or recognize for referring you to our practice.

Name: ______________________________ Phone Book: ______ Other: ______________

I have read the BAFD Financial Policy and agree to the terms therein, including paying the estimated patient's share at the time of service. I understand that a monthly service charge of 1½ % (18% annually) may be added to any balance not paid within 30 days.

______________________________ ______________ ______________

Signature of Patient or Guardian Relationship to Patient Date



BROKEN ARROW FAMILY DENTISTRY

Thank You For Choosing Our Office!

NAME ______________________ Date of Birth ______________________

MEDICAL HISTORY

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? .... Yes No
2. Has there been any change in your general health within the past year? .... Yes No
3. My last physical examination was on ______________________
4. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ______________________
5. The name and address of my physician is ______________________
   ____
   ____
6. Have you had any serious illness or operation? .... Yes No
   If so, what was the illness or operation? ....
7. Have you been hospitalized or had a serious illness within the past five (5) years? .... Yes No
   If so, what was the problem? ______________________
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur, mitral valve prolapse .... Yes No
   b. Congenital heart lesions .... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .... Yes No
      1. Do you have pain in the chest upon exertion? .... Yes No
      2. Are you ever short of breath after mild exercise? .... Yes No
      3. Do your ankles swell? .... Yes No
      4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? .... Yes No
      5. Do you have a cardiac pacemaker? .... Yes No
   d. Allergy .... Yes No
   e. Sinus trouble .... Yes No
   f. Asthma or hay fever .... Yes No
   g. Hives or a skin rash .... Yes No
   h. Fainting spells or seizures .... Yes No
   i. Diabetes .... Yes No
      1. Do you have to urinate (pass water) more than six times a day? .... Yes No
      2. Are you thirsty much of the time? .... Yes No
      3. Does your mouth frequently become dry? .... Yes No
   j. Hepatitis, jaundice or liver disease .... Yes No
   k. Arthritis .... Yes No
   l. Inflammatory rheumatism (painful swollen joints) .... Yes No
   m. Stomach ulcers .... Yes No
   n. Kidney trouble .... Yes No
   o. Tuberculosis .... Yes No
   p. Do you have a persistent cough or cough up blood? .... Yes No
   q. Low blood pressure .... Yes No
   r. Venereal disease .... Yes No
   s. Epilepsy .... Yes No
   t. Psychiatric problems .... Yes No
   u. Cancer .... Yes No
   v. AIDS or other immunosuppressive disorders .... Yes No
   w. Other .... Yes No

(over)

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? .... Yes No
   a. Do you bruise easily? .... Yes No
   b. Have you ever required a blood transfusion? .... Yes No
   If so, explain the circumstances ____________________

____

10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?. Yes No
12. Are you taking any drug or medicine? .... Yes No
   If so, what? ____________________
13. Are you taking any of the following:
   a. Antibiotics or sulfa drugs .... Yes No
   b. Anticoagulants (blood thinners) .... Yes No
   c. Medicine for high blood pressure .... Yes No
   d. Cortisone (steroids) .... Yes No
   e. Tranquilizers .... Yes No
   f. Antihistamines .... Yes No
   g. Aspirin .... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug .... Yes No
   i. Digitalis or drugs for heart trouble .... Yes No
   j. Nitroglycerin .... Yes No
   k. Oral contraceptive or other hormonal therapy .... Yes No
   l. Other ____________________
14. Have you ever taken any prescription diet medications? .... Yes No
15. Are you allergic or have you reacted adversely to:
   a. Local anesthetics .... Yes No
   b. Penicillin or other antibiotics .... Yes No
   c. Sulfa drugs .... Yes No
   d. Barbiturates, sedatives, or sleeping pills .... Yes No
   e. Aspirin .... Yes No
   f. Iodine .... Yes No
   g. Codeine or other narcotics .... Yes No
   h. Latex .... Yes No
   i. Other ____________________
16. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain ____________________

____

17. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
   If so, explain ____________________

____

18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? .... Yes No
19. Are you wearing contact lenses? .... Yes No
20. Have you had anything to eat or drink in the last 4 hours? .... Yes No
21. Are you wearing removable dental appliances? .... Yes No

Women

22. Are you pregnant? .... Yes No
23. Do you have any problems with your menstrual period? .... Yes No
24. Are you nursing? .... Yes No

Chief Dental Complaint

DATE ____________________

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____

Signature of Patient

Broken Arrow Family Dentistry

Consent to Use and Disclose Dental and Medical Information

Your signature on this form is an acknowledgement that you have received a copy of our Notice of Privacy Practices and gives your consent for our office to use and disclose the protected health information for the patient(s) listed below to carry out treatment, payment activities and healthcare operations.

- **Treatment:** includes activities performed by a dentist or other healthcare providers, as well as coordinating care with third parties, consultations involving dentists, physicians or other health care providers.
- **Payment:** includes activities involved in billing matters, determining eligibility for dental benefits, seeking payment for services we have provided, and obtaining pre-certification or pre-estimation for recommended treatment.
- **Health Care Operations:** includes associated business and administrative affairs of this office.

Notice of Privacy Practices: For further details regarding the possible use or disclosure of your information, we encourage you to read our Notice of Privacy Practices before you sign this consent form. We reserve the right to change our privacy practices and issue a revised Notice of Privacy Practices. You may request a current copy from our office at any time.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice. Please understand that revocation of this consent will not affect any action we took before we received your revocation, and we may decline to provide any further treatment after a revocation has been received.

Patient Names

Include yourself and any minors or adults for whom you have legal guardianship.
If you are signing for anyone other than yourself, please note your relationship to that patient.

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

I authorize Broken Arrow Family Dentistry to use and disclose the dental, medical and health information for myself and the minors listed herein.

Date: ___________ Signature: ____

Insurance Authorized Signature Form

I, the undersigned, expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered, or to be rendered, without obtaining my signature on each and every claim to be submitted for me and/or my dependents; and, that I will be bound by this signature as though I, the undersigned, had personally signed the particular form.

I understand that I am responsible for all costs of dental treatment and authorize payment directly to my dentist for all insurance benefits otherwise payable to me.

________________ ____

Date **Authorized Signature of Covered Employee**

____

Please Print Name