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

CHILD' S MEDICAL HISTORY

Information you give is strictly confidential and will not be released to anyone without your written permission.

PHYSICIAN: _____

Date of Last Physical: _____

DOES THE PATIENT CURRENTLY HAVE OR HAVE A HISTORY OF THE FOLLOWING:

YES	NO	
____	____	Rheumatic Fever
____	____	Heart Disease
____	____	Diabetes
____	____	Asthma
____	____	Allergies
____	____	Kidney Disease
____	____	Hepatitis
____	____	Seizures
____	____	Toothache
____	____	Allergic Reaction to any medications

if yes, what _____

____ ____ **IS THE PATIENT TAKING ANY DRUGS OR MEDICATIONS?**

if yes, what _____

____ ____ **IS THERE ANYTHING ELSE ABOUT THE PATIENTS HEALTH YOU FEEL WE SHOULD KNOW?**

if yes, what _____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING THE PATIENT'S DENTAL HISTORY:

YES	NO	
____	____	First dental visit?
____	____	Currently have toothache now or any discomfort?
____	____	Nervous about this appointment?
____	____	Ever had a bad experience at a dental appointment?
____	____	Brush his/her own teeth?
____	____	Eat many sweets?
____	____	History of thumb or finger sucking?

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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