

Toothbrusher's D E N T A L

NATHAN GUILFORD D. D. S.

Dental / Health History

Today's Date _____ SS# or Ins. ID# _____

Patient Name _____ Birthdate _____
Last First Middle Sex: Male Female

Address _____ Phone # _____
City State Zip

Email: _____ Cell Phone# _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Have you ever responded adversely to dental treatment? _____

Has a dentist ever asked you to take antibiotics before treatment (antibiotic prophylaxis)? Yes No

Have you ever had trouble "getting numb" during a dental procedure before? Yes No

Medical History

Physician's Name _____ Date and occasion of last visit _____

(Women) Do you suspect you are pregnant? Yes No Are you nursing? Yes No

Check (✓) if you ever had problems with any of the following

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

If patient is a child, what is his/her weight (for medication dosing reasons)? _____

Medications

Allergies

List medications you are currently taking _____
_____ Aspirin Penicillin
_____ Barbiturates (Sleeping pills) Sulfa
_____ Codeine Latex _____
_____ Local Anesthetic Other _____

Is there anything else we should know about your medical history? _____

Do you have a history of chemical dependency? _____

Work Information

Place of Employment _____ Address _____
City St Zip
Title _____ Phone # _____
Ext. _____

Emergency Contact

Please list an emergency contact (someone who doesn't live at your same address)

Name _____ Address _____
City St Zip
Phone # _____ Secondary Phone # _____

Please Initial Page _____

Payments and Insurance Claim Filing

We have made and will continue to make every effort to keep down the cost of your dental care. Our policy is to request payment at the time of your dental treatment. We try to avoid sending statements, because the cost of paperwork, postage and effort affect our fees.

If our office has a contract with your dental insurance company, we will submit charges to your insurance carrier at no extra cost, however, you will be required to pay any deductible, percentage or co-payment amount each time you have a dental procedure. Please know that even with insurance the ultimate responsibility of payment lies with the patient. We will gladly discuss your proposed dental treatment plan, and answer any questions relating to the office charges or dental fees. If we do not have a contract with your dental insurance company, we will submit charges to your insurance carrier at no extra cost, however realize that outside their network, insurance companies usually pay much less or none at all on their covered benefits. Your insurance is a contract between you and your company. No insurance company covers all dental costs. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge.

It usually takes three to four weeks for benefits to be paid. If after thirty days, the insurance company has not paid, we ask the patient to pay the balance of their amount due. We will continue to seek reimbursement from your insurance policy for a reasonable period of time. It may be necessary for you, the patient, to contact the insurance company to expedite payment. We do consider accounts past due after a thirty day period has passed from the date of the procedure.

Appointments and Cancellations

If it is necessary to cancel an appointment, we ask that you give us as much notice as possible...at least 24 hours...so that your reserved time can be made available to another patient. A fee of \$30 is applicable if notice is not given in this time period. Patients, who consistently miss appointments without notice, will not be rescheduled. We will provide a confirmation phone call to the number you provide us one business day prior to your scheduled time as a courtesy to you. However, you will be responsible for keeping track of your own appointment time and date.

Consent for Treatment

By signing this document you are giving general consent for treatment for yourself or your child. Specific treatment is always discussed prior to any treatment being rendered. During this time the patient is encouraged to ask any questions he or she may have about treatment. We do prefer that a parental presence is maintained in the waiting room if the patient is a minor, in case the need arises to discuss necessary changes in treatment.

Medical History

So that we can provide excellent dental care taking every precaution necessary, please notify us of any changes in your medical history. Also, please inform us of any change in your name, address, phone number, marital status, employment, or insurance coverage.

Parental Presence in Treatment Area

We do ask that you allow your child to accompany our staff without you through the dental experience. We are all highly experienced in helping children overcome anxiety. Certainly you know your child best and if you insist on being present we will not deny you this right, however studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an atmosphere designed for children without parental presence.

Signature

To the best of my knowledge, the above personal and health information is correct and complete. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health condition or medication. I have read and understand all office policies listed above.

Signature of Guarantor (person responsible for payment)

Date

Guarantor Birthday

Guarantor SS# or Ins. ID#

Print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Birthdate: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available online at www.toothbrushers.com or at our reception desk. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Honesty Norman

Telephone: 405 789-6935 Fax: 405 789-6987

E-mail: appointment@toothbrushers.com

Address: 4534 NW 50th St, Warr Acres OK 73122

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____