sooner DENTAL CARE

Patient Information

Date_____, 20____

Patient's Name_____ Male_____Female_____
Last First MI "Common Name"

Address_____
Street City State ZIP

Home Phone_____Work Phone_____Cell Phone_____

SS#_____ Email_____

Responsible Party Information

Patient DOB_____

Name_____Marital Status_____
Last First MI

Address_____DOB_____
Street City State ZIP

Home Phone_____Work Phone_____SS#_____

Employer_____Occupation_____No. Years employed_____

Spouse's Name_____DOB_____
Last First MI

Home Phone_____Work Phone_____

Employer_____Occupation_____No. Years Employed_____

Dental Insurance Information

Insured's Name_____Insured's SS#_____

Dental Insurance Company Address_____
Street City State ZIP

Date of Marriage_____Date of Employment_____Effective Date of Dental Insurance_____

Insured's Employer_____Employer's Address_____Phone_____

Do you have more than one dental insurance? YES NO *If YES complete the following*:

Insured's Name_____Insured's SS# and DOB_____
Last First MI

Dental Insurance Company_____Group No._____Local No._____

Insurance Company Address_____
Street City State ZIP

Insured's Employer_____Employer's Address_____Phone_____

Date of Employment_____Effective Date of Dental Insurance_____

Emergency Notification Information

In case of emergency, who should be notified?

Name_____Address_____Phone_____

Name_____Address_____Phone_____

**To the best of my knowledge all the preceding answers are true and correct.
I will inform your office of any changes at the next appointment.

_____
Signature of Patient or Guardian Date

*To whom may we thank for referring you to our office?*_____

Dental Questionnaire

Last First MI "Common Name"

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? [ ]Yes [ ]No
2. Have you ever had any serious trouble associated with previous dentistry? [ ]Yes [ ]No
3. Does dental treatment make you nervous? [ ]No [ ]Slightly [ ]Moderately [ ]Extremely
4. Date of last dental visit?_____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? [ ]Yes [ ]No
6. How often do you brush?_____Floss?_____ My tooth-brush is: [ ]Soft [ ]Medium [ ]Hard
7. Do you have or have you ever had any of the following:

MOUTH		**TEETH**	
Bleeding, Sore Gums	[ ] Yes [ ] No	Loose Teeth	[ ] Yes [ ] No
Unpleasant taste/bad breath	[ ] Yes [ ] No	Sensitive to HOT	[ ] Yes [ ] No
Burning tongue/lips	[ ] Yes [ ] No	Sensitive to COLD	[ ] Yes [ ] No
Frequent blisters, lips/mouth	[ ] Yes [ ] No	Sensitive to Sweets	[ ] Yes [ ] No
Swelling/lumps in mouth	[ ] Yes [ ] No	Sensitive to Biting	[ ] Yes [ ] No
Ortho treatment (braces)	[ ] Yes [ ] No	Food impaction	[ ] Yes [ ] No
Biting cheeks/lips	[ ] Yes [ ] No	Clenching/Grinding	[ ] Yes [ ] No
Clicking/Popping jaw	[ ] Yes [ ] No		
Difficulty opening or closing jaw	[ ] Yes [ ] No		
Do you use the following?			
Brush `	[ ] Yes [ ] No	Dental Floss	[ ] Yes [ ] No
Fluoride Rinse	[ ] Yes [ ] No	Other [ ] _____	

What do you feel is your major problem? (cavities, gum disease, toothache, worn teeth, crooked teeth, headaches, pain, jaw function, chewing, etc..)_____

_____

_____

[ ] Yes [ ] No Do you clench your teeth while you are sleeping?
[ ] Yes [ ] No Has anyone told you they have heard you grind your teeth while you are sleeping?
[ ] Yes [ ] No Must you chew on one side exclusively?
[ ] Yes [ ] No Do you have any symptoms upon waking in the morning such as:
[ ] Yes [ ] No Stiff Jaw? [ ] Yes [ ] No Sore Jaw? [ ] Yes [ ] No Headache?
[ ] Yes [ ] No Sore Teeth? [ ] Yes [ ] No Cracking or locking of either jaw joint (TMJ)?
[ ] Yes [ ] No Have you ever been treated for TMJ, TMD, jaw joint pain or discomfort? Who:_____

_____
Signature of Patient or Guardian Date

Medical Questionnaire

Correct answers to the following questions will allow your dentist to treat you so there **WILL NOT** be an emergency. However, if an emergency situation does arise this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

Do you have or have you ever had: NOTES:

Anemia [ ] Yes [ ] No

Diabetes [ ] Yes [ ] No

Allergies

To penicillin [ ] Yes [ ] No

To Latex [ ] Yes [ ] No

To local anesthetic [ ] Yes [ ] No

Other_____ [ ] Yes [ ] No

Cancer--benign/malignant [ ] Yes [ ] No

Abnormal heart condition or heart murmur [ ] Yes [ ] No

Abnormal bleeding from a cut [ ] Yes [ ] No

Rheumatic fever [ ] Yes [ ] No

Respiratory Disease or Asthma [ ] Yes [ ] No

Hepatitis [ ] Yes [ ] No

HIV/AIDS [ ] Yes [ ] No

Pregnant/breast feeding [ ] Yes [ ] No If pregnant, due date _____

Are you under the care of a physician now? [ ] Yes [ ] No

Are you taking any medication for pain or depression? [ ] Yes [ ] No

If yes, What?_____

Are you taking any other medications for any other reason? [ ] Yes [ ] No

If yes, What?_____

*Please comment on any medical or dental history that you feel may be important in the diagnosis and treatment of your condition. Please use the reverse side of this form if you need additional space.

_____

_____

_____

_____

_____

_____

Date of last medical examination?_____

Blood pressure_____

Name of Physician_____

Other Physical Conditions_____

Name of nearest relative_____

**Emergency Contact Phone Number_____

_____

Signature of Patient or Guardian Date

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Informed Consent & General Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but not limited to:

- Drug reactions: nausea, vomiting, drowsiness, and unexpected or allergic reactions.
- Cardiovascular or respiratory responses, which may lead to heart attack, stroke or death.
- Involvement of the nerves during oral surgery or administration of local anesthesia resulting in temporary or possible permanent numbness or tingling of the lip, chin, tongue, or other areas of the face or neck.
- Sinus involvement during the removal of upper molars, which may require additional treatment or surgical repair at a later date or by an oral surgeon.
- Incomplete removal of tooth fragments to avoid injury to vital structures such as nerves or sinus, occasionally small root tips may be left in place.
- Jaw fracture – while quite rare, it is possible in difficult or deeply impacted teeth.
- Breakage of dental instruments inside tooth canals requiring additional treatment.
- Damage to adjacent teeth or fillings.
- Post-operative complications may include: delayed healing of an extraction site, dry socket, infection, continued bleeding, bruising, swelling, sensitivity, or pain.

***While unfortunate, some dental procedures do fail and complications are possible.*

Any of the above conditions may indicate further treatment and/or a referral to a specialist if needed.

**In addition, it may be necessary to:

Contact patients via telephone and/or mail at home or at work. Use and/or disclose health/dental/information to healthcare providers, insurance companies, and/or, any other business associates regarding treatment, payment, or other healthcare operations.

All conditions apply unless requested by patient.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Appointment and Cancellation Policy

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge for not showing up for scheduled appointments. ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.***

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have received or asked for a copy of *Sooner Dental Care's* notice of Privacy Practices.

_____
Please Print Name

_____
Patient/Guardian Signature

_____
Date

Office Use Only

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

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: _____

_____

_____

_____

_____

_____
Witness Signature Date

sooner DENTAL CARE

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by / to anyone outside of our practice. You may gain access to this information if you desire. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and you rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect on April 14, 2003 and remains in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time provided, such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member picking up records, referral to dental specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give a written authorization, we cannot use or disclose your health information for any reasons except those described in this notice.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (included identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure or your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing any health information that is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences to your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Relation Services: Our dental office does not use patient information for any marketing purposes. We will not use your health information for marketing communications without your written authorization.

Required by Law: We may disclose your health information when it is required by law to do so (i.e. missing persons, etc.)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to lawfully authorize federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for any purpose, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these

additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing. It must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that 1) we may have violated your privacy right, 2) you disagree with a decision we made about access to your health information, 3) in response to a request you made to amend or restrict the use or disclosure of your health information or 4) to have us communicate with you by alternative means or at alternative locations, you may complain to the us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:	Sean Costello, DDS, Privacy Officer
Telephone:	918-742-1480
Address:	3150 E. 41st Street, Suite 100, Tulsa, Oklahoma 74105