RED OAK
SMILE
CENTER

PATIENT INFORMATION	CONFIDENTIAL
NAME ____________________	BIRTHDATE ____________________
ADDRESS ____________________	HOME PHONE ____________________
CITY ____________ STATE ________ ZIP ________	CIRCLE APPROPRIATE SELECTION:
PATIENT OR PARENT'S EMPLOYER ____________________	MINOR SINGLE MARRIED
BUSINESS ADDRESS ____________________	DIVORCED WIDOWED SEPERATED
CITY ____________ STATE ________ ZIP ________	WORK PHONE ____________________
IF PT IS A STUDENT, NAME OF SCHOOL ____________________	CELL PHONE ____________________
CITY ____________________ STATE ________	OTHER ____________________
WHOM MAY WE THANK FOR REFERRING YOU? ____________________	EMAIL ____________________

RESPONSIBLE PARTY	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________________	RELATIONSHIP TO PATIENT ____________
	HOME PHONE ____________________
ADDRESS ____________________	WORK PHONE ____________________
CITY ____________ STATE ________ ZIP ________	CELL PHONE ____________________
EMPLOYER ____________________	BIRTHDATE ____________________
ADDRESS ____________________	SS NUMBER ____________________
CITY ____________ STATE ________ ZIP ________	

INSURANCE INFORMATION

NAME OF INSURED ____

INSURANCE COMPANY ____

ADDRESS ____

CITY ________________________ STATE ______________ ZIP _________

PATIENT NAME ____

RELATIONSHIP TO PATIENT _________

BIRTHDATE ______________________

SS NUMBER ______________________

GROUP NUMBER ___________________

INSURANCE PHONE _______________

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ADDITIONAL INSURANCE

NAME OF INSURED ____

INSURANCE COMPANY ____

ADDRESS ____

CITY ________________________ STATE ______________ ZIP _________

RELATIONSHIP TO PATIENT _________

BIRTHDATE ______________________

SS NUMBER ______________________

GROUP NUMBER ___________________

INSURANCE PHONE _______________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____

- ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO
- DO YOU USE TOBACCO? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU USE COCAINE OR OTHER DRUGS? YES NO
- DO YOU WEAR CONTACTS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO

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  ____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

EXPLAIN ABOVE: ____

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PHYSICIAN PHONE _________________

DATE OF LAST EXAM _______________

WOMEN ONLY:

- ARE YOU PREGNANT ________
- ARE YOU NURSING _________
- ARE YOU TAING BIRTH CONTROL PILLS ____________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (*MARK ALL ANSWERS WITH A YES OR NO)*

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	KIDNEY DISEASE	___	___
HEART ATTACK	___	___	ANEMIA	___	___	AIDS/HIV INFECTION	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	STD'S	___	___

SWOLLEN ANKLES	___	___	CANCER	___	___	THYROID PROBLEMS	___	___
FAINING/SEIZURES	___	___	ARTHRITIS	___	___	HEPATITIS A, B OR C	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___	ULCERS	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	RESPIRATORY PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	OTHER ___________________________		
LEUKEMIA	___	___	STROKE	___	___	___________________________________		
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	___________________________________		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	___________________________________		
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___	___________________________________		
HEART MURMER	___	___	GLAUCOMA	___	___	___________________________________		
ANGINA	___	___	LIVER DISEASE	___	___			

PATIENT NAME ____

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ___________________________________
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ___________________________________
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ___________________________________
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? ___________________________________
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH? ___________________________________
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW? ___________________________________
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE? ___________________________________
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE? ___________________________________
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH? ___________________________________
10. DO YOU HAVE DIFFICULTY CHEWING? ___________________________________
11. DO YOU HAVE FREQUENT HEADACHES? ___________________________________
12. DO YOU CLENCH OR GRIND YOUR TEETH? ___________________________________
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ___________________________________
14. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK? ___________________________________
15. HAVE YOU EVER HAD BRACES? ___________________________________
16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? ___________________________________
17. HOW OFTEN DO YOU FLOSS? ___________________________________
18. DO YOU USE A MANUAL BRUSH OR ELECTRIC? ___________________________________
19. DO YOU USE ANY TYPE OF MOUTH RINSE? ___________________________________

GOALS FOR YOUR MOUTH, TEETH AND SMILE: _________________________

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IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? ____

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____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that

____
DENTIST SIGNATURE

providing false or incorrect information can be dangerous to my health.

______________________ PATIENT SIGNATURE	______________ DATE
______________________ PRINT NAME	

____
DATE

____
WITNESS SIGNATURE

____
DATE

This notice describes how Medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 469-820-9677.

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Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment, we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Red Oak Smile Center does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your*

Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Red Oak Smile Center maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Red Oak Smile Center.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Red Oak Smile Center occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement,

Signed____Date_____________

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
  We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date ________________ Signature_________________________________(Patient, Parent or Guardian)