Pearl District Dentistry

Patient Information

Name: ____ Date:_________________

Male or Female: _______ Marital Status: _________ SS#: ___________ Birthday: _________

Address: ______________________________ City:__________ State:______ Zip: _______

Phone: Home: _______________ Cell: _______________ Other: _______________

E-mail: _____________________________

Employer: ___________________________ Phone: ________________

Emergency Contact, Spouse or Responsible Party Information

Name: ____ Male or Female: _______

Relationship to patient: ___________________ Marital Status: _________ Birthday: _________

Address: ______________________________ City:__________ State:______ Zip: _______

Phone: Home: _______________ Cell: _______________ Other: _______________

E-mail: _____________________________

Insurance and Subscriber information

Subscriber: _________________________ Birthday: __________ SS #: _______________

Employer: ____________________________ Subscriber ID: __________________________

Group Name: ____________________ Group #: _________ Work Phone: _______________

Insurance Company: _____________________ Phone num: _____________________________

Address: ______________________________ City:___________ State: _____ Zip: ______

Relationship to patient: ___________________

Secondary

Subscriber: _________________________ Birthday: __________ SS #: _______________

Employer: ____________________________ Subscriber ID: __________________________

Group Name: ____________________ Group #: _________ Work Phone: _______________

Insurance Company: _____________________ Phone num: _____________________________

Address: ______________________________ City:___________ State: _____ Zip: ______

Relationship to patient: ___________________

Pearl District Dentistry

Health Information

Name: ______________________________ Date:________________

Medical History

Patient Physician: ______________________ Phone num: ________________

Date of last visit: ________________ Reason: ______________________________

Do you currently have any of the following? Have you ever had any of the following? (check all that apply)

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER:
  ____

Please describe any *medical condition* that was checked above: ______________________________

____

Medication: ____

Allergic to any medication? ☐ Yes ☐ No *If yes*, list: ______________________________

Have you experienced any unfavorable reactions to a local anesthetic or laughing gas? ☐ Yes ☐ No

Acknowledgment:

The information I have provided above is true and correct to the best of my Knowledge. I understand it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

Patient/Guardian Signature: ______________________________ Date: ________________

1646 E 6th Street Tulsa OK 74120 Phone: (918) 895-6933 Fax: (918) 576-6887

Pearl District Dentistry

Referral Information

Who may we thank for referring you to our practice? ☐ Dental Office ☐ Yellow Pages

☐ Newspaper ☐ School ☐ Work ☐ Another patient, friend ☐ Another patient, relative

☐ Other: ______________________ *Name of person or office referring you to our practice:* ______________________________

Appointment Reminder

Preferred method of contact for appointment confirmation:

☐ Phone call ☐ text message ☐ e-mail ☐ Facebook

I agree to be contact in the method above checked: Signature: ________________________ Date: ________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient or guardian: ____________________________ Date: ______________ Relationship_____________

Missed Appointment Policy

- We know your time is valuable and try to honor your appointment time.
- We try to always see our patients at their appointment time and try to complete as much treatment as possible.
- Missed appointments cause your treatment to take longer to complete.
- 24 hour notice is necessary to change an appointment. **If your appointment is not confirmed, it will be canceled.**
- If 2 appointments are missed, **they cannot be rescheduled without completing 1 work in appointment.** You can come in any day, during business hours, and wait to be seen. However, there is **no guarantee you will be seen**.

I, ______________________________________ have read and understand this information. _______ *(please initial)*

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I have received a copy of **Pearl District Dentistry** *Notices of Privacy Practices*.

____

Please Print Patients Name

____

Patient, Parent or Guardian Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other: ____.