CAPITOL HILL
DENTISTRY & BRACES

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us, we will be happy to help.

Patient Information
(Confidential)

☆ The Patient Speaks: ☐ English ☐ Spanish ☐ Both

Name: _____ Birthdate: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College: _____ City: _____ State: _____

Assisting to School: ☐ Full Time ☐ Part Time ☐ Not Attending.

Patient or Parent/Guardian's Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent/Guardian's Name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Responsible Party (If different from patient)

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Driver's License #: _____ Birthdate: _____ Financial Institution: _____

Employer: _____ Work Phone: _____ SS#: _____

Insurance Information

Name of Subscriber: _____ Relationship to Patient: _____

Insurance Company: _____ State: _____

Birthdate: _____ SS#: _____ Member ID: _____ Group #: _____

Home Phone: _____ Cell Phone: _____ Email: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Subscriber: _____ Relationship to Patient: _____

Insurance Company: _____ State: _____

Birthdate: _____ SS#: _____ Member ID: _____ Group #: _____

Home Phone: _____ Cell Phone: _____ Email: _____

How did you find out about our office? ☐ T.V ☐ Radio ☐ Brochure ☐ Internet ☐ Insurance Company

☐ Friend/Family (Name of the person who referred you: _____)

Medical History

Although our dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. It is important that you provide us with the following information:

Are you under a physician's care now?	◯Yes ◯No	If yes: _____
Have you ever been hospitalized or had a major operation?	◯Yes ◯No	If yes: _____
Have you ever had a serious head or neck injury?	◯Yes ◯No	If yes: _____
Are you taking any medications, pills, or drugs?	◯Yes ◯No	If yes: _____
Do you take, or have you taken Phen-Fen or Redux?	◯Yes ◯No	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯Yes ◯No	If yes: _____
Are you on a special diet?	◯Yes ◯No	
Do you use tobacco?	◯Yes ◯No	

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa
☐ Local Anesthetics ☐ Other: _____

Do you use controlled substances? ◯Yes ◯No If yes: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯Yes ◯No	Cortisone Medicine	◯Yes ◯No	Hemophilia	◯Yes ◯No	Radiation Treatments	◯Yes ◯No
Alzheimer's Disease	◯Yes ◯No	Diabetes	◯Yes ◯No	Hepatitis A	◯Yes ◯No	Recent Weight Loss	◯Yes ◯No
Anaphylaxis	◯Yes ◯No	Drug Addiction	◯Yes ◯No	Hepatitis B or C	◯Yes ◯No	Renal Dialysis	◯Yes ◯No
Anemia	◯Yes ◯No	Easily Winded	◯Yes ◯No	Herpes	◯Yes ◯No	Rheumatic Fever	◯Yes ◯No
Angina	◯Yes ◯No	Emphysema	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Rheumatism	◯Yes ◯No
Arthritis/Gout	◯Yes ◯No	Epilepsy or Seizures	◯Yes ◯No	High Cholesterol	◯Yes ◯No	Scarlet Fever	◯Yes ◯No
Artificial Heart Valve	◯Yes ◯No	Excessive Bleeding	◯Yes ◯No	Hives or Rash	◯Yes ◯No	Shingles	◯Yes ◯No
Artificial Joint	◯Yes ◯No	Excessive Thirst	◯Yes ◯No	Hypoglycemia	◯Yes ◯No	Sickle Cell Disease	◯Yes ◯No
Asthma	◯Yes ◯No	Fainting Spells/Dizziness	◯Yes ◯No	Irregular Heartbeat	◯Yes ◯No	Sinus Trouble	◯Yes ◯No
Blood Disease	◯Yes ◯No	Frequent Cough	◯Yes ◯No	Kidney Problems	◯Yes ◯No	Spina Bifida	◯Yes ◯No
Blood Transfusion	◯Yes ◯No	Frequent Diarrhea	◯Yes ◯No	Leukemia	◯Yes ◯No	Stomach/Intestinal Disease	◯Yes ◯No
Breathing Problems	◯Yes ◯No	Frequent Headaches	◯Yes ◯No	Liver Disease	◯Yes ◯No	Stroke	◯Yes ◯No
Bruise Easily	◯Yes ◯No	Genital Herpes	◯Yes ◯No	Low Blood Pressure	◯Yes ◯No	Swelling of Limbs	◯Yes ◯No
Cancer	◯Yes ◯No	Glaucoma	◯Yes ◯No	Lung Disease	◯Yes ◯No	Thyroid Disease	◯Yes ◯No
Chemotherapy	◯Yes ◯No	Hay Fever	◯Yes ◯No	Mitral Valve Prolapse	◯Yes ◯No	Tonsillitis	◯Yes ◯No
Chest Pains	◯Yes ◯No	Heart Attack/Failure	◯Yes ◯No	Osteoporosis	◯Yes ◯No	Tuberculosis	◯Yes ◯No
Cold Sores/Fever Blisters	◯Yes ◯No	Heart Murmur	◯Yes ◯No	Pain in Jaw Joints	◯Yes ◯No	Tumors or Growths	◯Yes ◯No
Congenital Heart Disorder	◯Yes ◯No	Heart Pacemaker	◯Yes ◯No	Parathyroid Disease	◯Yes ◯No	Ulcers	◯Yes ◯No
Convulsions	◯Yes ◯No	Heart Trouble/Disease	◯Yes ◯No	Psychiatric Care	◯Yes ◯No	Venereal Disease	◯Yes ◯No
						Yellow Jaundice	◯Yes ◯No

Have you ever had any serious illness not listed? ◯Yes ◯No If yes: _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Comments:

Doctor's Signature: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

CAPITOL HILL
DENTISTRY & BRACES

235 SW 25th St.
Oklahoma City, OK 73109
405-295-4967

Notice of Privacy Practices Acknowledgement & Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations, such as physician certifications and assessments.
- Obtain payment from third party payers, such as insurance companies.
- Confirm and leave messages at phone numbers provided to this office.

I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time, at the address above, to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payments or dental care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Broken and Cancelled Appointment Policy

When a patient misses a dental appointment without calling or showing up at the scheduled appointment date and time, this is a

BROKEN APPOINTMENT.

When a patient fails to cancel their dental appointment without providing the office with 24 hours' notice, this is a

CANCELLED APPOINTMENT.

After one "Broken Appointment", the patient will be placed on "Walk-in "status. (Meaning, you may walk in and we will try and Work you in the schedule around our already scheduled patients.

After one "Cancelled Appointment", we will reschedule your appointment, but if your appointment was during the high demand times, such as 3pm or later, your appointment will not be rescheduled to this appointment time.

Patient Name: _____ Date: _____

Signature of Patient or Guardian: _____

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **PROCESS ALL INSURANCE CLAIMS;**

2. **ENSURE PAYMENT FOR SERVICES PROVIDED**

3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS**

4. **RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to DOCTOR/PRACTICE NAME. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____

Patient Full Name (printed) _____

Parent Signature (if minor) _____

Witness _____

Date Signed _____