



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: _____)

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for the company's financial health and for providing reliable information to stakeholders.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps from initial entry to final review, ensuring that all necessary information is captured and verified.

3. The third part of the document addresses the role of the accounting department in this process. It highlights the need for clear communication and collaboration between different departments to ensure data accuracy.

4. The fourth part of the document discusses the importance of regular audits and reviews. It explains how these checks help identify errors early and prevent them from becoming major issues.

5. The fifth part of the document provides a summary of the key points discussed. It reiterates the importance of accuracy and the need for a systematic approach to record-keeping.

6. The final part of the document offers some concluding thoughts on the overall goal of the accounting process: to provide a clear and accurate picture of the company's financial performance.

The document is a detailed guide for the accounting department, covering various aspects of record-keeping and financial reporting. It is intended to serve as a reference for all staff involved in these processes.

The document is organized into several sections, each focusing on a different aspect of the accounting process. This structure allows readers to find the information they need quickly and easily.

The document is written in a clear and concise style, using simple language to explain complex concepts. This makes it accessible to a wide range of readers, from new employees to experienced accountants.

The document is a valuable resource for the accounting department and for all staff involved in financial reporting. It provides a comprehensive overview of the accounting process and offers practical advice on how to perform it effectively.

The document is a key component of the company's financial management system. It helps ensure that all transactions are recorded accurately and that the company's financial statements are reliable.

The document is a critical tool for the accounting department. It provides the necessary guidance and information to ensure that the company's financial records are accurate and up-to-date.

The document is a comprehensive guide to the accounting process. It covers all the major areas of accounting, from record-keeping to financial reporting, and provides detailed instructions on how to perform each task.

The document is a valuable resource for the accounting department and for all staff involved in financial reporting. It provides a clear and concise overview of the accounting process and offers practical advice on how to perform it effectively.

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

Faint, illegible text on the left page of the document, appearing as a series of horizontal lines.

Faint, illegible text on the right page of the document, appearing as a series of horizontal lines.



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: _____

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2. The second part of the document outlines the specific procedures for recording transactions. It details the steps from identifying a transaction to entering it into the accounting system, ensuring that all necessary details are captured and verified.

3. The third part of the document addresses the role of the accounting department in monitoring and controlling the company's financial performance. It discusses how regular reviews and audits can help identify potential issues and ensure compliance with relevant regulations.

4. The fourth part of the document focuses on the importance of transparency and communication in financial reporting. It highlights the need for clear and concise reports that provide a comprehensive overview of the company's financial position.

5. The fifth part of the document discusses the impact of financial reporting on the company's reputation and its ability to attract investment. It notes that accurate and timely reporting is essential for building trust and confidence among investors and other stakeholders.

6. The sixth part of the document concludes by summarizing the key points discussed and reiterating the importance of a strong financial reporting system. It encourages the company to continue to refine its processes and maintain the highest standards of accuracy and integrity.

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: _____

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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 _____

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