Moore Smiles Family Dentistry

WELCOME
Thank you for Selecting Moore Smiles

To help us meet all your healthcare needs, please legibly fill out this form in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

1. Patient Information (Confidential)

Date _____
Name _____ Preferred Named _____
SS# _____ Date of Birth _____
Physical Address _____ City, State _____
Zip Code _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
Check Appropriate: ___Minor ___Single ___Married ___Separated ___Divorced ___Widowed
If Student, Name of School Attending _____

If Parents are divorced, with whom does the child reside?
Name _____
Physical Address _____ City, State_____
Zip Code _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____

Person to Contact in Case of Emergency _____ Phone _____
Who may we thank for referring you? _____

2. Responsible Party

Name of Person Responsible for this Account _____
Relationship to Patient _____
Physical Address _____ City, State _____
Zip Code _____
Home Phone _____ Cell Phone _____

3. Insurance Information

Name of Primary Insured _____
Relationship to Patient _____
Date of Birth _____ SS# _____
Name of Employer _____ Employer's Phone Number _____
Insurance Company _____ Member ID# _____
Group Number _____

4. Patient Medical History

Have you been advised to take a Premedication of Antibiotics prior to Dental Appointments? Y N

Physician _____ Office Number _____

Are you undergoing medical treatment now? Y N

Have you been hospitalized for any surgical operations or serious illnesses? Y N

If yes, please explain

_____

_____

Do you take Aspirin Daily Y N

Do you take Blood Thinners or Anti-Inflammatory Medications? Y N

If yes, please list

_____

_____

Are you taking any medication(s) including non-prescription medications? Y N

If yes, please explain

_____

_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Y N

Are you allergic to or have you had any reactions to the following?

Dental Anesthetics	Y N
Penicillin	Y N
Sulfa Drugs	Y N
Household Bleach	Y N
Aspirin	Y N
Latex	Y N
Codeine	Y N
Other (Please List)	Y N

_____

Do you use tobacco or vape? Y N

Do you use controlled substances? Y N

Do you or have you had any of the following?

Anemia	Y N	Stomach Problems/Ulcers	Y N
High Blood Pressure	Y N	Emphysema	Y N
Heart Attack Date _____	Y N	Back Problems	Y N
Rheumatic Fever	Y N	Arthritis	Y N
Fainting/Seizures	Y N	Artificial Bones/Joints Type _____	Y N
Asthma	Y N	Venereal Disease	Y N
Low Blood Pressure	Y N	Sinus Problems	Y N
Epilepsy/Convulsions	Y N	Glaucoma	Y N
Leukemia	Y N	Blood Disease	Y N
Diabetes	Y N	Headaches/Migraines	Y N
Kidney Disease	Y N	Jaw Problems TMJ/TMD	Y N
AIDS/HIV	Y N	Liver Disease	Y N
Thyroid Problem	Y N	Mental Disorders	Y N
Heart Disease	Y N	Respiratory Issues	Y N
Heart Murmur	Y N	Stroke Date _____	Y N
Angina	Y N	Scarlet Fever	Y N
Allergies	Y N	TB ACTIVE? Y N	Y N
Mitral Valve Prolapse	Y N	Alcohol/Drug Abuse	Y N
Heart Stents Date _____	Y N	Blood Transfusion	Y N
Cancer Type _____	Y N	Chest Pains	Y N
Cosmetic Surgery	Y N	Heart Surgery Date _____	Y N
Hepatitis A B C	Y N	Blood Disease	Y N
Prolonged Bleeding	Y N	Radiation/Chemotherapy	Y N
Shortness of Breath	Y N	Shingles	Y N

Women Only

Are you pregnant or think you may be pregnant? If yes, how many weeks? _____ Y N

Are you currently breastfeeding? Y N

Are routinely taking oral contraceptives, implants, hormone therapy, etc.? If yes, what kind _____ Y N

Consent: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. The undersigned hereby authorizes Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connections with the above patient and further authorize and consent that the Doctor chooses and employs such assistance as he deems fit.

Patient/Guardian's Signature _____ Date_____

5. Patient Dental History

Date of Last Exam and Cleaning _____

Date of Last Full Mouth or Panoramic X-rays _____
Have you ever had: (Choose all that apply)
___Orthodontics ___Periodontal Treatment ___Oral Surgery ___Worn any type of Appliance
___Had your bite adjusted
Problems of the Jaw: (Choose all that apply)
___Clicking of the jaw ___Pain (joint, ear, side of face) ___Difficulty chewing ___Difficulty opening
How often do you brush your teeth?
___Once a day ___Twice a day ___Every other day ___Twice a week ___When you remember

What brand of toothpaste do you use? _____
What type of toothbrush texture do you use?
___Soft ___Medium ___Hard/Firm

Are you having pain at this time?	Y N
Have you noticed any loosening of the teeth?	Y N
Do your gums bleed while brushing/flossing?	Y N
Does food tend to get caught between your teeth?	Y N
Do you suffer from pain and/or swelling of your gums?	Y N
Do your ever feel self-conscious about your breath?	Y N
Do you bite your lips or cheeks frequently?	Y N
Do you brush/scrape your tongue?	Y N
Do you have any sore or lumps in or near your mouth?	Y N
Are your teeth sensitive to sweet/sour liquids or foods?	Y N
Are your teeth sensitive to hot/cold liquids or foods?	Y N
Do you clench or grind your teeth?	Y N
Have you ever had any difficult extractions in the past?	Y N
Is it important to keep your teeth?	Y N
Are you dissatisfied with the appearance of your teeth?	Y N
Are you interested in teeth straightening?	Y N
Do you feel nervous about having dental treatment?	Y N
Have you ever had an upsetting experience in a dental office?	Y N

Is there anything else the Dental Hygienist or the Dentist needs to know?

_____

_____

Patient/Guardian's Signature_____ Date_____

Authorization for the Release of Protected Health Information

Patient Name _____

Address _____

Telephone Number _____ Social Security Number _____

I authorize the following Protected Health Information to be disclosed (Select all that applies):

- ☐ All dates of service
- ☐ The following dates of service _____
- ☐ Dependent (s) claim information (list the dependents) _____
- ☐ Financial Information
- ☐ Plan or Benefit coverage information
- ☐ Appeal status or information
- ☐ Any other information regarding my account and/or dependent (s) _____

Please list Names, Relationship and Contact Number to those that your Protected Health Information (PHI) can be released to either written or verbally.

1. Name _____ Relationship _____

   Phone Number _____

2. Name _____ Relationship _____

   Phone Number _____

3. Name _____ Relationship _____

   Phone Number _____

This authorization will automatically expire on _____/_____/_____.

I, _____, have had full opportunity to read and consider the content of this authorization form. I understand that, by signing this form, I am confirming my authorization that Moore Smiles Family Dentistry may use and /or disclose my protected health information (PHI) to the person or entity named on this form for the purpose described above. I understand this authorization is voluntary and confirms my consent to the described activity. I understand that I have the right to revoke this authorization at any time.
I understand that the revocation of this authorization will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my revocation to the following entity: Moore Smiles, Attention: Privacy Officer; 3001 South Telephone Rd., Ste. A; Moore, Oklahoma 73160.

Patient's signature _____ Date _____

If a person other that the Patient signs this form, please complete the following:

Personal Representative's Name _____ Relationship _____

Moore Smiles Family Dentistry

WRITTEN FINANCIAL POLICY

Thank you for choosing Moore Smiles. We are committed to providing you with the highest quality dental care using the best material and technology available. We are also committed to providing you with the up-to-date information and educational tools so that you can fully participate in maintaining optimum oral health. An important part of the mission is making the cost of your dental care easy and manageable by offering several payment options.

Payment Options:

You can choose from:

- ☐ Cash, Check, Visa, MasterCard, American Express, Discover and Care Credit
- ☐ We offer a 10% courtesy discount to patients that pay for their treatment with check or cash that are not covered by insurance or a discount dental plan.
- ☐ We offer a 5% courtesy discount to patients that pay for their treatment by credit card that are not covered by insurance or a discount dental plan.

Please note:

All charges you incur are your responsibility. If you have dental insurance, we can estimate what out of pocket expense will be for a procedure based on the information given by your insurance company. We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. *Your insurance is a contract between you, your employer and the insurance company*. Therefore, we cannot guarantee payment of your claims or accept the responsibility of negotiating claims with your insurance company or any other person. **If your insurance pays only a portion of the billed charges or rejects your claim, you are responsible for full payment for services rendered.**

All copays and/or out of pocket expenses are due at the time services are rendered unless prior arrangements have been made with the office manager.

Fees:

Please be aware that our office charges an $8.00 fee on most services for the disposal of infectious materials. Some insurance companies require our office to write the fee off stating that we are not to charge the patient. However, some insurance companies state that the patient is responsible for the $8.00 infection control fee.

Appointment Agreement:

Therefore, we request that you honor your reserved appointment as scheduled: Should you have to change your appointment, we request 24 business hours' notice. Failure to give 24 business hours' notice will result in a $40 charge applied to your account. Failure to show for your scheduled appointment will also result in the additional $40 charge.

Our office hours are 7:30 a.m. to 4:30 p.m., Monday thru Thursday.
We now require all scheduled appointments to be confirmed by noon the business day prior to the appointment, if it is not confirmed, the appointment will be cancelled.

Billing:

Effective March 1, 2010, each 2nd statement and subsequent statement will incur a $5.00 rebilling charge.

If you have any questions, please do not hesitate to ask. We are here to help you get the best dentistry that you want and need.

_____ _____

Patient/Guardian Signature Date

_____

Patient Name (Please print legible)

Larry D. Leemaster, D.D.S., P.C.
dba Moore Smiles Family Dentistry

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

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 barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

Moore Smiles Family Dentistry

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS

Patient Name _____ Date of Birth _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice with any updates to my email address.

I can withdraw my consent to electronic communications by calling: **405-793-8300**

Email Address (PLEASE PRINT LEGIBLY):

_____

Patient Signature _____ Date _____