

# WELCOME

## Patient Information

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_  
Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Occupation \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## Dental Insurance

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)  
Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## Phone Numbers

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

## Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you wear contact lenses?  Yes  No

**Women:**

Are you pregnant?  Yes  No Due date \_\_\_\_\_ Are you nursing?  Yes  No  
 Taking birth control pills?  Yes  No

### Medications

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_

### Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

### Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No  
 For what conditions? \_\_\_\_\_  
 Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No  
 For what conditions? \_\_\_\_\_  
 Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Laura B. Ousley

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## Consent For Use And Disclosure of Health Information

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**Section B: To the patient—Please read the following statements carefully**

**PURPOSE OF CONSENT:** By signing this form, you will consent to use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

**NOTICE OF PRIVACY PRACTICES:** You have the right to read our Notice of Privacy Practices before you sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Your may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Laura B. Ousley, D.D.S.  
11205 N. May Ave. Ste. A  
OKC, Ok. 73120  
755-4450

**RIGHT TO REVOKE:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT FOR TREATMENT AND RELEASE

1. I Hereby authorize the doctor(s) or designated staff to take radiographs, study models, photographs, and any other diagnostic aids or procedures deemed by the doctor(s) to make a thorough diagnosis of dental needs for me or my child.
2. Upon such diagnosis, and with full knowledge that complications can occur, I authorize the doctor(s) to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care for me or my child.
3. I agree to the use of anesthetics, sedative, and other medication as necessary for my child or me. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I authorize release of any information concerning my or my child's healthcare, advice, and treatment provided for the purpose for evaluating and administering claims for insurance benefits.
5. I authorize release of any information, including radiographs or records, concerning my or my child's health care, advice and treatment to another doctor.
6. I hereby authorize payment of insurance benefits directly to the doctor, otherwise payable to me.
7. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services.
8. I agree to be responsible for payment of all services rendered on my behalf or my dependent's. I understand that payment is due at the time of service except for the portion of payments from assigned insurance benefits. Full payment is due within sixty days. In the event that full payment is not received within sixty days from the date of service, I agree to pay any balance over sixty days old immediately. I understand that for any balance over sixty days, a 1½ % late charge (18% APR) will be added to my account.
9. If I am unable to make payment at the time of service to completely clear my account, I agree to allow the doctor(s) to evaluate my credit record for the purposes of extending credit.
10. I hereby state that I have read and understand this consent, and that all questions about the procedures have been answered in a satisfactory manner, and I understand that I have the right to be provided answers to the questions which arise during and after the course of my treatment.
11. By signing this statement, I revoke all previous agreement to the contrary and attest to the accuracy of the information on the reverse side of this page.

Patient or Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_