PRECISION DENTAL AND DENTURES

1419 N Main St Jay OK 74346 Office 918-253-3331 Fax 888-213-4547

PERSONAL INFORMATION

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name
Mailing Address: _____ City _____ State _____ Zip _____
Gender: M F Marital Status: Married Single Divorced Widowed
Date of Birth: _____ Social Security #: _____
Employer: _____ Work Phone: _____
Cell Phone: _____ May we text you? Yes No
Home Phone: _____ Preferred Contact Method: Home Cell Work
Email Address: _____
If patient is a child:
Mother's Name _____ Employer: _____ SS# _____
Father's Name _____ Employer: _____ SS# _____

INSURANCE

Do you have dental insurance? Yes No Please provide card
Insurance Company: _____ ID #: _____ Group #: _____
Policy Holders Name: _____ Policy Holders SSN: _____ DOB _____
Policy Holder's Employer: _____ Relationship to policy holder: Self Spouse Child

PRIVACY POLICY FOR HIPAA COMPLIANCE

I may refuse to sign this acknowledgement. I have been offered and/or received a copy of Precision Dental & Dentures' Notice of Privacy Practices. I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.
Expiration: Three (3) years from Initial Signature; Insurance Change; Patient reaches age of 18
I consent for the office of Dr Christopher Wilcox to share my personal information with the following: (family, friends, etc.)

1) _____ Relationship: _____ Phone#: _____

2) _____ Relationship: _____ Phone#: _____

_____ _____
Signature ☐ Patient ☐ Parent ☐ Guardian/Other Date

FINANCIAL POLICY

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERRED. NEW PATIENT EMERGENCY VISITS **MUST BE PAID** ON THE DAY OF SERVICE.
1. I request that payment of dental/healthcare benefits be made on my behalf to Precision Dental & Dentures for any services provided to me. I authorize any holder of medical/dental information about me to release to my private insurance any information needed to determine these benefits payable for related services. I hereby authorize Precision Dental and Dentures to affix my name to all insurance submissions, documents and/or information requested by my insurance company relating to any and all health benefits due me and my dependents. **I am responsible for paying any deductible or co-insurance required by my insurance company. In addition, I am responsible for paying any non-covered service.**
2. Precision Dental & Dentures does not accept assignment of benefits on a secondary insurance policy. We will file a secondary claim but ask that you pay the portion that your primary insurance does not cover as patient responsibility.
3. Payment Options: For your convenience we accept all credit cards, personal checks, cash and Care Credit. Should your check be returned by the bank for any reason there is a $15.00 returned check fee charged to your account.
4. I authorize Precision Dental & Dentures to exam me and to perform such test and procedures as are necessary in the diagnosis and treatment of my care. If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient's behalf.

_____ _____
Signature of Patient or Legal Guardian Date

MEDICAL HISTORY

Medical Doctor: _____ Phone Number: _____
Has a physician ever told you that you had to pre-medicate prior to dental treatment? YES NO
Do you currently take any blood thinners? YES NO Please List _____
Are you currently taking medicine for osteoporosis? YES NO
Do you bleed excessively upon injury? YES NO
Do you have a lung or respiratory condition that requires the use of oxygen? YES NO
Do you have chest pains? YES NO
Are you under a physician's care for pain management? YES NO
Are you allergic to any of the following? None Codeine Penicillin Iodine Sulfa Aspirin Latex Metals
Other allergies? _____
PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING: _____

_____

Please mark if you have had any of the following

- ☐ AIDS/HIV
- ☐ ALCOHOL ___ Drinks per day/Week ___Social
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINTS WHEN_____
  WHAT KIND _____
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ CANCER WHEN_____
  WHAT KIND _____
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HAY FEVER
- ☐ HEAD INJURIES WHEN _____
  WHAT KIND _____
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS A B C
- ☐ HIGH BLOOD PRESSURE
- ☐ JAUNDICE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MEMORY TROUBLE
- ☐ MENTAL DISORDER _____
- ☐ NERVOUS DISORDER
- ☐ OSTEOPOROSIS
- ☐ PACEMAKER
- ☐ PREGNANT (NOW)
- ☐ RADIATION TREATMENT WHEN_____
  TREATMENT FOR_____
- ☐ RESPIRATORY PROBLEMS _____
  CPAP / BiPAP DEVICE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ TOBACCO ____CURRENT ___ FORMER
  SMOKE/PIPE/VAPE ____ PACKS PER DAY
  CHEW/DIP SNUFF ____ CANS PER DAY
- ☐ TB/LUNG DISEASE
- ☐ ULCERS
- ☐ VENEREAL DISEASE
- ☐ OTHER (PLEASE LIST BELOW)

Please list any conditions not mentioned: _____

_____

The answers I have given are true to the best of my knowledge. By signing below I am indicating consent for routine dental procedures such as x-rays, cleanings, fillings, crowns, and local anesthesia.

_____ _____

Signature of Patient or Legal Guardian Date