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