

PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name: Last		First		Middle	
Address: Street or P.O. Box #		City		State Zip code	
Pager#:		Cell Phone:		Email Address:	
Age: Yrs.		Birth Date: Mo. Day Year		Birthplace:	
Social Security No: (if child, parents)		Driver's License No:			
Occupation:		Employer:		How long employed?	
Person responsible for bill:		Age:		Address:	
		Relationship:		Social Security No:	
Occupation:		Employer:		How long Employed?	
Employer Address & Phone No:					

Insurance Information

Insured Person's Full Name		Date of Birth	
Social Security Number		Relationship to Patient	
Insurance Company Name		Group or Union Name	
Employer's Name		Full Address of Employer	
Work Phone		Group or Local Numbers	

Getting to Know You

<p>1. Why did you select our practice? _____</p> <p>2. Whom may we thank for referring you? _____</p> <p>3. Is another member of your family or relative a patient in our practice? _____</p> <p>4. Person to contact for emergency: _____ Phone: _____</p>	<p>5. When was your last dental visit? _____</p> <p>6. When was the last time you had complete dental radiographs taken? _____ Name and Address of last Dentist: _____</p> <p>7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants</p>
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Payment Alternatives

<p>Please check appropriate box:</p> <p><input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.</p> <p><input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided.</p> <p><input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.</p>	<p>This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.</p> <p><input type="checkbox"/> 4. Mastercard, Visa, Discover and American Express</p> <p><input type="checkbox"/> 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.</p>
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FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party

Relationship

Date

MEDICAL HISTORY

1. How do you feel about getting and maintaining a healthy mouth? _____
2. How do you feel about the appearance of your teeth? _____
3. If you could change anything about your smile, what would you change? _____
4. Are you having dental problems at this time?..... Yes No
5. Do your gums bleed at any time?..... Yes No
6. Do you feel very nervous about having dental treatment?..... Yes No
7. Have you ever had a bad experience in the dental office?..... Yes No
8. Have you been under the care of a medical doctor during the past two years?..... Yes No
If yes: for what reason? _____
Please provide the name, address, and telephone number of your physician. _____
9. Have you been a patient in the hospital during the past two years?..... Yes No
If yes: for what reason? _____
10. Have you taken any medicine or drugs during the past two years? If yes, please list:..... Yes No
11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:..... Yes No
12. Have you ever had excessive bleeding requiring special treatment?..... Yes No
13. Do you use any tobacco products?..... Yes No
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... Yes No
15. Do your ankles swell during the day?..... Yes No
16. Have you lost or gained more than 10 pounds in the last year?..... Yes No
17. Do you use more than 2 pillows to sleep?..... Yes No
18. Do you ever wake up from sleep short of breath?..... Yes No
19. Are you on a special diet?..... Yes No
20. Check any of the following which apply in either past or present:

<input type="checkbox"/> Heart Valve Prolapse	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cortisone Medication
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Family History of Cardiovascular Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> X-Ray or Cobalt Treatment
<input type="checkbox"/> Angina Pectoris (chest pain)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cancer or Tumors
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> HIV Positive (AIDS)
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Cold Sores or Fever Blisters
<input type="checkbox"/> Artificial Joint of Any Type	<input type="checkbox"/> Any Form of Eating Disorder	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Diet Medication: Name _____	<input type="checkbox"/> Recreational Drug Use	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Drug Addiction/Alcoholism	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Any Form of Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Birth Control Medication
<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Pregnant – Due Date _____
21. Do you have any disease, condition or problem not listed? If so, please list..... Yes No



LAKE POINTE
DENTAL

(405)946-5558 phone
www.LakePointeDentalOKC.com
10914 Hefner Pointe Drive, #150
OKC, OK

Smile Evaluation

1. Do you like the way your teeth look? Yes _____ No _____
Explain _____
2. Are you happy with the color of your teeth? Yes _____ No _____
Explain _____
3. Would you like your teeth to be whiter? Yes _____ No _____
Explain _____
4. Would you like your teeth to be straighter? Yes _____ No _____
Explain _____
5. Do you have spaces between your teeth you would like closed?
Yes _____ No _____
If so, where? _____
6. Would you like your teeth longer? Yes _____ No _____
If so, Upper _____ Lower _____
7. Do you have missing teeth you would like replaced? Yes _____ No _____
Explain _____
8. Do you like the shape of your teeth? Yes _____ No _____
Explain _____
9. Do you have old silver fillings you would like replaced with tooth-colored fillings? Yes _____ No _____
Explain _____
10. If you could change anything about your smile, what would you change?
Explain _____

I agree to let Lake Pointe Dental team to take photos of me to utilize for
educational or promotional purposes.

Signature: _____

Date: _____



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Contact Information For Protected Health Information

I, _____, Date of Birth: _____,
request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es) tests results, dates of service.

Please Check All That Apply

- You may disclose information to my family members and/or non-family members. Please list name, phone number and relationship.

Name	Phone Number	Relationship

- You may leave Protected Health Information on my answering machine/ voicemail/ email.

Phone Number: _____

Email: _____

- Other: _____

- You may disclose insurance information to a referring dental office.

Patient's Signature: _____ Date: _____

Patient's Printed Name

Social Security Number

Patient's Signature (or Guardian, if minor)

Date

Witness (optional)

Date



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Notice Of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Lake Pointe Dental Group's Notice of Privacy Practices.

Please 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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

To be retained in patient's file.

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Lake Pointe Dental Group and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anaesthesia, radiographs (x-rays), or diagnostic aids.
 - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
 - D. Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants).
 - E. Removal (extraction) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and/or soft).
 - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
 - H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
 - I. Use of general anaesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that this risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anaesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anaesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that either are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instruction of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____ AM/PM File No. _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

Signature: Patient or Parent or Guardian _____

Witness: _____

