MEDICAL HISTORY

OAKFIELD DENTAL

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Patient name: _____

Date of birth: _____

Emergency contact & phone: _____

Primary care doctor name & phone: _____ Last physical exam: _____

Pharmacy name, phone /address: _____

Y/N | Do you smoke / smokeless tobacco / E-cigarettes? Frequency: _____

Y/N | Have you used controlled substances in the past 48 hours? Explain: _____

Taking any illicit drugs can impair judgement, so you would not be allowed to sign a consent form
Taking cocaine and receiving anesthetic with epinephrine can be fatal

Y/N | Taken Phen-Fen, Redux, or bisphosphonate medications in the past 15 years?

(i.e. Fosamax/Binosto (Alendronate), Actonel/Altevia (Risedronate), Reclast/Zometa/Aclasta (Zoledronic acid), Boniva (Ibandronate), Didronel (Etidronate), Aredia (Pamidronate), Skelid (Tiludronic acid))

Check one: ☐Pill form ☐Injection Start & end dates: _____

Y/N | Recent surgeries within the past 5 years? Date: _____ Explain: _____

Y/N | History of head and neck injury? Explain: _____

Y/N | Are you pregnant / trying / nursing? Due date: _____

Y/N | Taking oral contraceptives? *Taking antibiotics can prevent oral contraceptives from working*

Allergies or adverse reactions:

☐ None	☐ Clindamycin	☐ Local Anesthetic	☐ Pine Nuts
☐ Acrylic	☐ Dyes	☐ Metals	☐ Steroids
☐ Codeine	☐ Latex	☐ Penicillin/ Amoxicillin	☐ Sulfa Drugs
☐ Other: _____			

Y/N | Heart Issues/ Surgeries	Y/N | Epilepsy/ Seizures	Y/N | Emphysema	Y/N | Cancer
Y/N | Heart attack/ Failure	Y/N | Fainting Spells/ Dizziness	Y/N | Frequent Cough	Y/N | Chemotherapy
Y/N |Heart Pacemaker	Y/N | Stroke	Y/N | Sinus Issues	Y/N | Radiation
Y/N | Heart Stent	Y/N | CPAP for Sleep Apnea	Y/N |Swelling of Limbs	Y/N | Immunocompromised
Y/N | Chest Pain/ Angina	Y/N | Bleeding Disorder	Y/N | Arthritis	Y/N | Cold Sores/ Fever Blisters
Y/N | Congenital Heart Defect	Y/N | Excessive Bleeding	Y/N | Osteoporosis	Y/N | Herpes
Y/N | Mitral Valve Prolapse	Y/N | Anemia	Y/N | Stomach/ Intestinal Disease	Y/N | AIDS/ HIV+
Y/N | Irregular Heartbeat/ Murmur	Y/N | Sickle Cell Disease	Y/N | Acid Reflux/ GERD	Y/N | Tuberculosis
Y/N | Artificial Heart Valve/ Joint	Y/N | High Blood Pressure	Y/N | Diabetes Type I / II	Y/N | Shingles
Y/N | Require Antibiotic Pre-Med	Y/N | Lung Disease	Y/N |Thyroid/ Parathyroid Disease	Y/N | Hepatitis A, B, C
Y/N | Psychiatric Condition	Y/N | Asthma	Y/N |Cortisone Medication Use	Y/N | Liver Disease
Y/N | Alzheimer	Y/N | COPD	Y/N | High Cholesterol	Y/N | Kidney Disease/ Dialysis
Y/N | Dementia			

Y/N | Any other medical conditions, serious illnesses, hospitalizations, or accidents?

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Last cleaning? Why did you switch dentists? _____

Any known uncompleted dental treatment or problems? _____

Anything we should know to improve your experience? _____

Have you experienced any of the following?

Y/N | Jaw joint (TMJ) pain	Y/N | Sensitive teeth	Y/N | Can't lean back fully in dental chair
Y/N | Grind/clench	Y/N | Dry mouth	Y/N | Happy with shade of teeth
Y/N | Wear a night/bite guard	Y/N | Past deep cleaning	Y/N | Happy with arrangement of teeth

Are you taking any medications?

☐ No medications ☐ List scanned in ☐ Please list below:

MEDICATION NAME	PURPOSE

I attest to the accuracy of the information and understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status at the very next appointment, before any further treatment is rendered.

Print patient/guardian name: _____ Relationship: _____

Patient/guardian signature: _____ Date: _____

Doctor's signature: _____ Date: _____

OAKFIELD DENTAL

I understand that I have certain rights and privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Oakfield Dental.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and the disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy with this restriction. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I authorize the release of or discussion of protected health information including the diagnosis, records, treatment recommended or rendered, and claims information to:

❑ Information is not to be released to anyone

Name: _____ Relationship:_____

Name: _____ Relationship: _____

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.
Print patient/guardian name: _____ Relationship: _____

Patient/guardian signature _____
Date: _____

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HIPAA PATIENT CONSENT FORM

OAKFIELD DENTAL

I understand that I have certain rights and privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Oakfield Dental

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I authorize the release of or discussion of protected health information including the diagnosis, records, treatment recommended or rendered, and claims information to:

❑ Information is **not** to be released to anyone

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print patient/guardian name: _____ Relationship: _____

Patient/guardian signature _____ Date: _____

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INFORMED CONSENT GENERAL DENTAL PROCEDURES

OAKFIELD DENTAL

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alter treatment, or options of no treatment.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post-op treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

Drugs and Medications:
I understand that antibiotics, analgesics, and other medication can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient initials: _____

Changes in Treatment Plan:
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. The most common occurrence being cavities that are larger than what was seen clinically or on the x-ray, which may require further treatment such as including additional surfaces of a tooth found to be infected, placing an indirect pulp cap for cavities approximating the pulp of a tooth, or resulting in root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes as necessary.

Patient initials: _____

Print patient/guardian name: _____ Relationship: _____

Patient/guardian signature _____ Date: _____

Initials _____

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PATIENT FINANCIAL AGREEMENT

OAKFIELD DENTAL

1. I understand that full payment is due at the time of service for myself or any of my dependents. If I do not have my payment, I understand that my appointment may be rescheduled.

2. A returned check will result in a $25 service charge and all future payments being required in the form of cash or credit card.

3. You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if the credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.

4. As a courtesy, we will try to provide you with insurance information to the best of our ability. However, I understand that it is solely my responsibility to confirm which treatments or procedures are covered by my insurance (including but not limited to any exclusions, deductibles, annual/lifetime maximum).

5. I understand that the insurance claims will only be filed if I provide the office with my social security number or insurance ID number. Should I choose not to provide that information, I must pay fully for all services rendered.

6. I understand that the insurance estimate on the treatment plans may be different from what my insurance carrier ultimately pays, and I am responsible for any amounts not paid by my insurance for any reason. It is my responsibility to ask for a pre-determination if I want a more accurate estimate.

7. I understand that if I discontinue treatment for any requested procedure, including, but not limited to partial or complete dentures, crowns, bridgework, and surgical preparatory work, I remain responsible for paying all lab-related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled to, for discontinuing treatment.

8. I understand that I must inform Oakfield Dental in writing of any concerns, questions, or disputes I may have concerning my treatment and charges in a timely manner.

9. I understand that all account balances over 30 days will be charged a 1.5% monthly compound interest.

10. If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

Initials _____

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PATIENT FINANCIAL AGREEMENT

OAKFIELD DENTAL

11. I understand that Oakfield Dental currently charges $30.00 for a broken or cancelled appointment without a 24 hour notice. For broken or cancelled appointments occurring on a Saturday, I may not be allowed to schedule again on a Saturday.

12. I understand that it is my responsibility to immediately notify the office of any changes to my address, phone number, email address, work contact information, work status, insurance changes, and etc.

13. I authorize payment of dental benefits otherwise payable to me directly to Oakfield Dental. I further give authorization to deposit checks received on my account when payable in my name.

14. I authorize confirmation of my dental appointments, recall appointments, and outstanding treatment reminders by phone, text, or email unless I inform the office of non-participation.

I was referred by: _____

I consent to receiving text messages. Initials: _____

I consent to receiving email reminders. Initials: _____ Email address: _____

Please mark your preferred method(s) of communication:

___ Home phone ___ Cell phone ___ Text message ___ Email

If unable to reach me,

___ You may leave a detailed message
___ Please leave a message asking me to return your call
___ Do not leave a message

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you. I have read and understand the above Financial Policy and agree to meet all financial obligations.

Print patient/guardian name: _____ Relationship: _____

Patient/guardian signature _____ Date: _____

OAKFIELD DENTAL

Patient Consent Form

I understand that I have certain right privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and the disclosures of my protected health information and my rights under **HIPPA**. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy with this restriction.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However any use or disclosure that occurred prior to the date I revoke this consent is not affects.

Print Patient Name:_____

Patient/Guardian Signature:_____

Date:_____

Relationship to patient:_____