OIL CITY DENTAL **1347 S. BEVERLY STREET, CASPER, WY 82609** **307-577-0577**

PATIENT INFORMATION

NAME: ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Rev_____
First MI Last

DOB _____ Social Security _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone: _____ Work _____

Are you: ( ) Minor Child ( ) Married ( ) Single ( ) divorced ( ) Widowed ( ) Separated

EMERGENCY CONTACT

NAME_____ PHONE _____

RESPONSIBLE PARTY INFORMATION (MUST SIGN FINANCIAL AGREEMENT)

NAME: _____
First MI Last

DOB _____ Social Security _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone: _____ Work _____

INSURANCE INFORMATION

SUBSCIBERS NAME:

_____
First MI Last

DOB _____ Social Security _____

Address: _____
Mailing City State Zip

Home Phone _____ Cell Phone: _____ Work _____

EMPLOYER _____INSURANCE COMPANY NAME_____

ADDRESS_____PHONE_____GROUP#_____ID# _____

MEDICAL HISTORY AND CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Full Name _____ **D.O.B.**_____

Allergies

Acrylics	Y	N
Anaphylaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

_____

GENERAL

Current Weight _____lbs

Height ___ft___in

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
STD	Y	N
Knee/Hip replacement	Y	N
Liver Problems	Y	N
Recent Trauma/Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

MUSCULOSKELETAL

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Replacement	Y	N

Date_____

Osteporosis	Y	N
Arthritus	Y	N

CARDIOVASCULAR

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain / Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

ENDOCRINE

Diabetes	Y	N
Gout	Y	N
Hormonal Changes	Y	N
Thyroid Problems	Y	N

NEUROLOGICAL

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

DO YOU REQUIRE

Pre Medication	Y	N
Blood Thinners	Y	N
Bisphosphonates	Y	N

Hematological

Bleeding Issues	Y	N
Hepatitis A/B/C	Y	N
HIV/AIDS	Y	N

PSYCHIATRIC

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorders	Y	N
Excessive Stress	Y	N
Memory Problems	Y	N

EYES, EARS, NOSE AND THROAT

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus	Y	N

ORAL

Bleeding Gums	Y N
Dry Mouth	Y N
Orthodontic Treatment	Y N
Tooth Pain	Y N
Wisdom Tooth Extraction	Y N
Periodontal Disease	Y N
Teeth Clenching	Y N
Teeth Grinding	Y N
Dentures / Partials	Y N
Jaw Problems (TMJ)	Y N
Clicking	Y N
Pain	Y N
Difficulty Swallowing	Y N
Difficulty Chewing	Y N

RESPIRATORY

Asthma	Y N
Bronchitis	Y N
Breathing Problems	Y N
Chest Pressure	Y N
Congestion	Y N
Dyspnea (Short of breath)	Y N
Emphysema	Y N
Orthopnea	Y N
Pneumonia	Y N
Pulmonary Embolism	Y N
Tuberculosis	Y N
COPD	Y N

Genitourinary

Frequent Urination	Y N
Kidney disease	Y N
Nocturia	Y N

Gastrointestinal

Acid Reflux	Y N
Gerd	Y N
Special Diet	Y N
Ulcers	Y N

WOMEN ONLY

Pregnant	Y N
Nursing	Y N
Oral Contraception	Y N

SLEEP

Daytime Sleepiness	Y N
Morning Headaches	Y N
Obstructive Sleep Apnea	Y N
CPAP Device	Y N
How Often _____	
Snoring	Y N

SOCIAL HISTORY

Do you smoke?	Y N
Packs per Day _____	
Use Smokeless Tobacco	Y N
Consume Alcoholic Beverages	Y N
_____Drinks per Day/Week/Month	
Use Recreational Drugs	Y N

1. **Reason for visit** _____
2. **When was your last dental visit?** _____
3. **How often do you brush your teeth?** _____
4. **What texture tooth brush do you use?** **SOFT** **MEDIUM** **HARD**
5. **Do your gums bleed when brushing?** Y N
6. **Do your gums bleed when flossing?** Y N
7. **Do you feel pain when bushing/flossing?** Y N
8. **Are your teeth sensitive to hot, cold, sweet?** Y N
9. **Have you noticed loosening of your teeth?** Y N
10. **Do you get food caught between your teeth?** Y N
11. **Sores or lumps in or near your mouth** Y N
12. **Head or neck injuries?** Y N
13. **Frequent headaches?** Y N
14. **Have you ever had an unfavorable dental experience?** Y N

Full Name _____ **D.O.B.**_____

MEDICAL HISTORY AND CONSENT

Medications List:

Medication	Dosage/Freq	Reason
1.		
2.		
3.		
4.		
5.		
6.		

List of surgeries or hospitalizations:

Date (year)	Surgery	Reason

List and detail any medical condition or history not listed above:

_____

_____

_____

Primary Care Physician _____ **Phone Number** _____

Are you currently under the care of a physician? Y N Physician _____

Reason _____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Oil City Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Oil City Dental to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Oil City Dental choose and employ such assistance as deemed necessary. I understand that the use of local anesthetic agents embodies certain risk and consent to their use as deemed appropriate by Oil City Dental. To the best of my knowledge, the questions on this form have been accurately answered. I Understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dentist office of any changes in medical health or status.

Consent (ADULT)

Name of Patient _____ _____ _____

Signature of Patient Date

Consent (CHILD)

Name of Patient _____ _____ _____

Signature of Parent/Guardian Date

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize Oil City Dental to release any information, including the diagnosis and records of the treatment or examination rendered to me during the period of such dental care to third party payers and/or other healthcare providers.

I authorize and hereby request my insurance company to pay directly to the dentist (Oil City Dental, LLC) insurance benefits otherwise payable to me.

I understand that my medical and/or dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of Insured _____ Date_____

OIL CITY DENTAL, LLC FINANCIAL OFFICE POLICY

1. Payment is due at time of treatment
2. We accept, Cash, Check, Visa, MasterCard and Discover
3. We offer outside financing through CareCredit
4. Accounts not paid in full by the end of the month will be assessed a billing fee of 1.75% per month (21% annual)
5. If you have insurance, we will file your claims as a courtesy. However, any balance not paid by your insurance is your responsibility.
6. There will be a charge assessed of $25 for appointments canceled without 24 hours notice.

Signature of Financial Responsible Party_____Date_____

I the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me, or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement I will pay interest thereon at the rate of 1.75% (21% annual) and pay all reasonable attorney fees and court cost that may be incurred. I agree that in the event this agreement is assigned to agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature of Financial Responsible Party_____Date_____

CONSENT FOR TREATMENT

I hereby authorize Oil City Dental and its associates to perform necessary dental services for myself or my dependent child, including, but not limited to, X-rays, Intraoral examination, and anesthetics deemed advisable by the doctor. I acknowledge there are no court orders in effect that prohibit me from signing this consent.

Signature of Patient/Parent/ Guardian_____**Date**_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____

Address_____

Telephone_____ Email_____

Patient ID#_____ Social Security #_____

SECTION B: TO THE PATIENT- Please read the following statements carefully.

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

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to 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 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 our protected health information that we maintain.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OR OUR NOTICE AT ANY TIME BY CONTACTING:

Contact Person:	Kristie Mooney
Telephone:	307-577-0577 Fax: 307-234-4655
Email:	oilcitydental@gmail.com
Address:	1347 S. Beverly St. Casper, WY 82604

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 above. Please understand that your 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 continue treating you if you revoke this consent.

SIGNATURE:

I, _____have had full opportunity to read and consider the consents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Court Orders Relating to Minor Children: In the event of a court order for shared information concerning minor children, it is the responsibility of the custodial parent or parent accompanying the minor child to provide the pertinent information to this office on this form. If the information is not provided, the non-custodial parent must provide court documentation to their right to obtain the protected health information concerning the minor child. If the documentation is provided to this office, the information will be disclosed per the court order.

Name of Parent/Guardian to which information can be released:

_____

Address: _____

Phone Number: _____

Signature_____ Date_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representative's Name_____
Relationship_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____ have received a copy of this office's Notice of Privacy Practices.

PATIENT NAME:_____

SIGNATURE: _____ DATE_____

FOR OFFICE USE

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

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please specify)