T-Town Smiles

PATIENT HEALTH HISTORY

INDIVIDUAL INFORMATION

Patient Name	Gender	DOB	SSN
Address	City, ST ZIP		Employer
Primary Phone	Secondary Phone	Email	

SPOUSE / EMERGENCY CONTACT INFORMATION

Name	Phone	DOB	Relationship to Patient
Address		City, ST ZIP	

WHO REFERRED YOU TO OUR OFFICE?

INSURANCE INFORMATION

Name of Carrier	Subscriber Name	DOB	SSN or ID# / Group #

MEDICAL HISTORY

Primary Physician_____ Approximate Last Visit _____ Phone Number _____

Current Health Condition ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you had any serious health problems in the last 5 years? ☐ Yes ☐ No
If yes, please explain
_____

What pharmacy do you use? _____ Location:_____ Phone: _____
Are you currently taking any medication? ☐ Yes ☐ No If yes, please list:

Medication	Reason prescribed	Medication	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you require pre-medication for dental treatment: ☐ Yes ☐ No

WOMEN ONLY: Are you currently pregnant? ☐ Yes ☐ No If yes, how many months? _____
Are you taking oral contraceptives? ☐ Yes ☐ No

Have you been, or are you currently being treated for:

Abnormal bleeding	☐ Yes	☐ No	Fainting spells	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
AIDS/ARC/HIV+	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hay fever	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No	Hepatitis A/B/C	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney trouble	☐ Yes	☐ No	Allergy-Aspirin	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No	Liver trouble	☐ Yes	☐ No	Allergy-Codeine	☐ Yes	☐ No
Cancer/Tumors	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Allergy-Dental Anesthetics	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Mental Illness	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Allergy-Latex	☐ Yes	☐ No
Drug/alcohol abuse	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Allergy-Metals	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation therapy	☐ Yes	☐ No	Allergy-Penicillin	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No	Allergy-Sedatives	☐ Yes	☐ No

Please list any surgeries or medical conditions: _____

_____

DENTAL HISTORY

Are you dissatisfied with your teeth and their appearance?	☐ Yes	☐ No
Have you had cavities in the last three years?	☐ Yes	☐ No
Do you experience dry mouth?	☐ Yes	☐ No
Do you suffer from acid reflux/GERD?	☐ Yes	☐ No
Are you deeply concerned about the finances required to return your teeth to excellent dental health?	☐ Yes	☐ No
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐ Yes	☐ No
Do you smoke/chew tobacco? How many per day?	☐ Yes	☐ No
Do you vape? How often?	☐ Yes	☐ No
Do you use cannabis? How often?	☐ Yes	☐ No
Do you drink alcohol? How many drinks per day/week?	☐ Yes	☐ No
Have you had any teeth removed? How long ago?	☐ Yes	☐ No
Do you believe you will eventually require dentures?	☐ Yes	☐ No

So that we are able to suit your individual needs, which do you feel most applies to you?

Check one: ☐ I want to maintain my teeth for a lifetime
☐ It is not important to keep my teeth for a lifetime

Check one: ☐ I want the best dental care available for myself; please recommend anything that you feel is necessary for good oral health
☐ I want good dental care for myself, but there is a limit to what I am able to have done

Check one: ☐ I want to learn as much as I can about dental health care; please explain in detail what is needed or has been done
☐ I would prefer to have summarized what is needed or has been done

Previous Dentist _____ Last Dental Exam _____/_____/_____ Last Dental X-rays_____/_____/_____

Number of times a day you brush? _____ Number of times a week you floss? _____

Why did you choose to leave your previous dentist? _____

_____

ACCOUNT INFORMATION / FINANCIAL RESPONSIBILITY

Person responsible for account _____ Relationship to Patient _____

Billing Address _____ City, ST _____ ZIP_____

Primary Phone_____ Secondary Phone_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid my in insurance company.

I hereby certify that I have read and understand the above information to the best of my ability. I have been given an opportunity to ask questions and these questions have been answered to my satisfaction. The questions on this form have been answered accurately. I understand that incorrect information can be dangerous to my health.

Patient Name (printed) _____ Date _____

Patient or Guardian Signature _____

T-Town Smiles

AUTHORIZATION AND RELEASE

INSURANCE

Initial _____

By signing this agreement, I am indicating that I understand and agree that T-Town Smiles, PC can only estimate the amount my insurance company will pay toward each dental procedure and are not able to guarantee what my insurance company will pay. I am solely responsible for all fees, including those not paid by my insurance company. T-Town Smiles, PC will file my insurance, as a courtesy, only under these terms. Any claims not paid by my insurance within 60 (sixty) days of treatment will be due immediately, and it will be my responsibility to file for any reimbursements from my insurance company.

FINANCIAL RESPONSIBILITY

Initial _____

Payment for dental/medical treatment must be made when the treatment plan is accepted, or at the time treatment is provided, unless prior financial arrangements have been made.

By signing this agreement, I am indicating that I agree to the terms of this agreement, including being responsible for all legal fees, costs and an annual interest rate of 22% in the event that you breach this agreement. This agreement will be considered breached, by me, if T-Town Smiles, PC has not received payment in full within 30 (thirty) days of your receipt of the final bill.

CANCELLATION POLICY

Initial _____

Non-emergency cancellations require 24 hours notice. Emergency cancellations are accepted only for illness, illness of immediate family member and/or a death in the family. A change in work schedule, lack of childcare, family events, etc. are not considered as emergencies. All other appointments must be canceled no later than 24 hours before the appointment. After two non-emergency cancellations within any calendar year patients will be deactivated from patient status. All appointments that are canceled without proper notification will be billed at $75 per hour scheduled with your provider. This fee is non-refundable.

RELEASE OF MEDICAL RECORDS

Initial _____

I hereby authorize T-Town Smiles, PC to release copies of all information in my dental/medical records to other dental/medical providers or insurance carriers as a part of or result of my treatment and/or to any other organization for the sole purpose of obtaining payment for dental/medical services provided to or for myself or my dependents. I authorize release of records/photos for educational purposes to other dental/medical providers. I understand that this release will remain valid until revoked, by me, in writing.

I hereby certify that I have read and understand the above information to the best of my ability. I have been given an opportunity to ask questions and these questions have been answered to my satisfaction. The questions on this form have been answered accurately.

Patient Name (printed) _____ Date _____

Patient or Guardian Signature _____

T-Town Smiles

6565 E. Yale Ave.
Suite 1107
Tulsa, OK 74136
918-481-4922

Acknowledgment of Receipt of Privacy Practices

I authorize the following people to be able to receive information regarding my dental health:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize T-Town Smiles, PC to contact me, and leave messages as needed, via:

☐ Phone (landline or mobile) ☐ Text message ☐ Email

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA info and consent form and any subsequent changes in office policy. I understand that this consent shall remain in force for the next 3 calendar years.

I acknowledge that I have received and understand T-Town Smiles, PC *Notice of Privacy Practices* containing a description of the uses and disclosure of my health information. I further understand that T-Town Smiles, PC may update is *Notice of Privacy Practices* at any time and that I may receive an updated copy of T-Town Smiles, PC's *Notice of Privacy Practices* by submitting a request in writing for a current copy.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Representatives Name Relationship to Patient

_____ _____
Patient Representatives Signature Date

For Official Office Use Only

T-Town Smiles, PC made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign.

☐ Patient or patient's personal representative unable to sign.

☐ Other: _____