TIME 08:09 AM DATE 5/17/2021

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Financial P Signed

Referred By

Emergency Number

Pref Day(s)for Appts

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Bluff Creek Dental

MEDICAL HISTORY

Patient Name: Birth Date:

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

Are you under a physician's care? If yes, name of your physician and approximate date of last visit.	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Do you have a history of cancer? If yes, what type and approximately when?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you experience breathing problems or have a breathing disorder/disease?	○ Yes ○ No	If yes
Have you been diagnosed with an autoimmune disease? How is the condition being treated?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Diabetes	○ Yes ○ No
Hepatitis A	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Angina	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Arthritis	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No
Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Bleeding Abnormally	○ Yes ○ No
Hives or Rash	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Dry Mouth	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No
Sinus Trouble	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems/Dialysis	○ Yes ○ No
Back Problems	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Swelling of Limbs	○ Yes ○ No	Glaucoma	○ Yes ○ No	Thyroid Condition	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever-Seasonal	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Tonsillitis	○ Yes ○ No	Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Herpes	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Attention Deficit Disorder	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Autism Spectrum Disorder	○ Yes ○ No	Chemical Dependency	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No
Sleep Apnea	○ Yes ○ No				

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law.

You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our Website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability

Act of 1996 (HIPAA).

The Patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations.

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this

Notice.

The Practice reserves the right to change the Notice of Privacy Policies.

The Patient has the right to restrict the uses of their information.

The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the

patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full

for any services will be required.

This HIPAA Consent was signed by: _____ _____

Patient/Guardian Signature Date

BLUFF CREEK DENTAL

15101 Crown at Lone Oak Rd
Edmond, OK 73013-2258

Thank you for choosing Bluff Creek Dental. Our primary mission is to deliver the best and most comprehensive dental care available. For your convenience, we are pleased to offer you the following payment options to assist you in attaining optimal dental health.

- **PAYMENT IS DUE AT TIME OF SERVICE**
- **FORMS OF PAYMENT:** Cash, Check, Visa, MasterCard and Discover. We will be happy to keep your card on file for convenient payments.
- **DISCOUNTS:** We offer a courtesy adjustment for payment in full when you receive major dental treatment. Our business manager can give you further details.
- **INSURANCE:** As a ***courtesy***, we offer to file insurance claims to a patient's primary insurance carrier. Estimated co-pays are due at time of service. Additional insurance claims for secondary insurance carriers may be filed at the discretion of a billing specialist.
- **FAILURE TO PAY:** If it becomes necessary for Bluff Creek Dental to seek legal representation to assist in collecting amounts owed and not paid by the patient, then the patient hereby agrees to be responsible for Dr. Crowley's reasonable and necessary costs and attorney's fees of collection.
- **FINANCING:** No or low interest payment plans with no down payment necessary in most cases are available thru Care Credit.
- **INTEREST CHARGES:** We reserve the right to charge 1.5% interest monthly on accounts with balances over 60 days.
- **CANCELLATIONS:** We have a strict policy regarding the need to cancel or alter a reserved appointment. The office must receive a 48-business hour notice of any changes. If the appointment is on a Monday, we must hear from you no later than noon on Thursday. ***** Any appointment scheduled for 90 minutes or greater will require a deposit equal to 20% of your portion of the scheduled treatment. In the event that the appointment is cancelled within 48 hours of the scheduled appointment time, your deposit is non-refundable. ******

Please be aware that we can not guarantee any estimate and that there may be a balance after insurance pays. Rarely does an insurance company cover 100% of your dental treatment. We will do our best to estimate your deductible and insurance co-payment of your dental plan. However, any remaining balance is your direct responsibility. This includes any non-covered services, yearly deductible and/or co-payments for your particular insurance plan.

To honor time reserved for our patients, a charge of $50 will be applied for cancelled or missed appointments without 48-hour notice. I understand and agree to the above policy.

_____ _____

Signature of patient or guardian Date

Disclosures

- Bluff Creek Dental charges a $25 service charge for returned checks, and will be filed with the District Attorney.
- If you have any questions, please do not hesitate to ask. We are here to help you receive the best dental treatment.