

**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**

**Section 3**

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: \_\_\_\_\_

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



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.