WELCOME

ABOUT YOU

Today's Date: ____________

Patient Full Name: ____________

What you prefer to be called: ____________

O Male O Female Age: ____________

Date of Birth: ____________

SS#: ____________

Mailing Address: ____________

____

Cell Phone: ____________

Work Phone: ____________

Email Address: ____________

Referred by: ____________

Employer: ____________

Employment Address: ____________

____

Status: OMinor OSingle O Married O Divorced O Separated O Widowed

Spouse's Name: ____________

Children? O Yes O No

INSURANCE INFO

PRIMARY DENTAL INSURANCE

Insured's Name: ____________

Date of Birth: ____________

SS#: ____________

Insurance Name: ____________

Insurance ID#: ____________

Group #: ____________

Insurance Phone #: ____________

Insurance Address: ____________

____

Company Name: ____________

SECONDARY DENTAL INSURANCE

Insured's Name: ____________

Date of Birth: ____________

SS#: ____________

Insurance Name: ____________

Insurance ID#: ____________

Group #: ____________

Insurance Phone #: ____________

Insurance Address: ____________

____

Company Name: ____________

ACCOUNT INFO

Person ultimately responsible for account

Name: ____________

Date of Birth: ____________

SS#: ____________

Relation: ____________

Cell Phone: ____________

Work Phone: ____________

Billing Address: ____________

____

______ *Initials* I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I full understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

EMERGENCY CONTACT

Name: ____________

Relation: ____________

Cell Phone: ____________

Work Phone: ____________

Patient's Medic. Doctor: ____________

Doctor's Phone: ____________

Preferred Pharmacy & Location:

____

continue on back

DENTAL INFORMATION

Are you in pain? 0 Yes 0 No If so, how long? ______________________

Please indicate any of following problems: 0 Discomfort, clicking or popping in jaw

0 Lost/broken fillings 0 Stained teeth 0 Broken/chipped tooth 0 Blisters/sores in or around the mouth

0 Teeth grinding 0 Locking jaw 0 Sensitive tooth, teeth, or gums 0 Red, swollen or bleeding gums

0 Ringing in ears 0 Bad breath 0 Active decay/cavity(ies) 0 Other: ____________________

What can do to help fix your smile/teeth? ____

____

Have you ever been treated for gum disease? 0 Yes 0 No 0 Don't know

Previous Dentist, Location, & Phone: ____

Last Dental exam: __________ Last Dental X-rays: _________ Last Dental Cleaning: _________

Have you had orthodontic treatment before? 0 Yes 0 No

MEDICAL HISTORY & INFORMATION

Do you require pre-medication? 0 Yes 0 No 0 Don't know

Current medications: 0 Nerve pills 0 Pain killers (including aspirin) 0 Muscle relaxers 0 Stimulants

0 Blood thinners 0 Tranquilizers 0 Insulin 0 Osteoporosis meds

0 Vitamins/Supplements: ____

0 DAILY Medications: ____

____

____

Have you ever taken any of the following? 0 Bisphophonates *(ex. Aredia/Fosamax)* 0 Phen-fen/Redux

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Heart Attack/Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Disease/Angina
Y N Shingles	**Y N** Lung Disease	**Y N** Thyroid Problems	**Y N** Congenital Heart Defect
Y N Cancer/Tumor(s)/Growth(s)	**Y N** Hepatitis	**Y N** Liver Problems	**Y N** Seizures/Epilepsy
Y N Artificial Heart Valves	**Y N** Chemotheraphy/Radiation	**Y N** Glaucoma	**Y N** Blood disease
Y N Venereal Disease	**Y N** Mitral Valve Prolapse	**Y N** X-ray or Cobolt Treatment	**Y N** Arthritis/Gout
Y N Kidney Problems	**Y N** Cosmetic Surgery	**Y N** G.I. Problems/Ulcers	**Y N** Frequent Thirst/Urination
Y N Leukemia	**Y N** Scarlet Fever	**Y N** Dizziness/Fainting	**Y N** Emphysema/Asthma
Y N Bleeding Problems/Anemia	**Y N** Chest Pains	**Y N** Tuberculosis TB	**Y N** Cold/Fever Blisters
Y N Diabetes/Hypoglycemia	**Y N** High/Low Blood Pressure	**Y N** Bruise Easily	**Y N** HIV+/AIDS/ARC
Y N Blood Transfusion	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Allergies
Y N Rheumatic Fever	**Y N** Alcohol/Drug Abuse	**Y N** Back/Neck Problems	**Y N** Severe/Frequent Headaches
Y N Nervousness	**Y N** Sinus Problems	**Y N** Eating Disorder	**Y N** Respiratory Problems
Y N Jaw Problems TMJ/TMD	**Y N** Sleep Apnea		

List other medical conditions and/or past surgeries: __________________________________

____

Are you allergic to any of the following? 0 Latex 0 Penicillin/Amoxicillin 0 Tetracycline 0 Aspirin

0 Codeine 0 Dental Anesthetics 0 Foods: ______________ 0 Others: ___________________

Do you use tobacco? 0 Yes 0 No If so, how used, how much, & how long? ________________

FOR WOMEN: Are you taking birth control pills? 0 Yes 0 No Hormonal replacements? 0 Yes 0 No

Are you pregnant? 0 Yes 0 No If so, how far along? ___________ Are you nursing? 0 Yes 0 No

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature: ____ **Date:** ____________________

GREEN COUNTRY DENTAL ARTS

Dr. John Lard
Dr. Wesley Thompson
Dr. Brendon Swisher
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Bartlesville, Oklahoma 74006
(918) 336-1030

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ________________________________ Date: __________

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Green Country Dental Arts' Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Expiration -- 3 Years from Initial Signature; Insurance Change; Patient reaches age of 18

I consent for the office of Green Country Dental Arts to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

___________________________ /________________ / ________________

___________________________ /________________ / ________________

Signature: ____

☐ Patient ☐ Parent ☐ Guardian / Other