PATIENT REGISTRATION
AND
MEDICAL/DENTAL HISTORY

Medical Alert

Pharmacy Name_____ Phone_____

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.
(PLEASE PRINT)

Date_____

Home Phone_____ Work Phone_____ Cell/Pager _____ Email _____

Patient Name_____

Address_____

City_____ State_____ Zip_____ Social Security #_____ Driver's Lic.#_____

Sex: ❑ Male ❑ Female Age_____ Birthday ___/___/___ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed By_____

Occupation_____

Business Address_____

City_____ State_____ Zip_____ Tel._____

Spouse Name_____ Birthday ___/___/___

Employed By_____

Business Address_____

City_____ State_____ Zip_____ Tel._____

Social Security #_____

Person Responsible For Account

Name: _____ Relation:_____

Billing Address: _____

_____

Hm# ( ) _____ DL#_____

Employer: _____

Wk# ( ) _____ Ext:_____ SS#_____

Dental Insurance Primary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

Dental Insurance Secondary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

In case of emergency, who should be notified?_____ Tel._____

Whom may we thank for referring you?_____

Medical History

Physician's Name_____ Date of Last Physical_____

Address_____ Tel._____

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.

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

☐ AIDS/ HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain In Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe: _____

Circle "Yes" or "No" for each item.

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No

Are any of your teeth sensitive to:

Hot or cold	Yes	No
Sweet	Yes	No
Biting or chewing	Yes	No

Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or a change in your bite?	Yes	No

Do you have difficulty in chewing on either side of the mouth?	Yes	No
Are you happy with your smile?	Yes	No
Are you pleased with the color of your teeth?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: are you

☐ Pregnant / Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. _____

Staff/ Dr.'s Initials Date

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

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

_____ _____

Signature of Patient or Parent of Minor Date

SOUTHWEST DENTAL GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **4/01/03**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or other person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your heath information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy or your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Southwest Dental Group
1007 W. Oak Ave.
Duncan, OK 73533

Telephone: 1-580-255-6621
Fax: 1-580-252-7345

(This form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law change may require revision.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's notice of privacy practices.

Please Print Name

_____

SIGNATURE

_____

DATE

_____

For office use only

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**
- **COMMUNICATIONS BARRIERS PROHIBITED OBTAINING**
- **AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT**
- **OTHER (PLEASE SPECIFY)**

SOUTHWEST DENTAL GROUP, DR ROBERT D. SCHICK D.D.S.
1007 WEST OAK AVE
DUNCAN, OK 73533
580-255-6621

SOUTHWEST DENTAL GROUP
1007 WEST OAK AVE
DUNCAN, OK 73533
580-255-6621
WWW.BESTDUNCANDENTIST.COM

PERMISSION TO DISCUSS MEDICAL INFORMATION

All medical/dental records are confidential. We require written authorization to release medical information to anyone other than the patient. **By signing the authorization below, you are giving us permission to discuss the information contacted in your medical/dental information with another individual.**

I, _____, give Dr. Robert Schick and staff of Southwest Dental Group permission to discuss my diagnosis, procedures and/or treatment plan including fees with.

Please list name(s)

Signature_____ Date_____

Printed name_____

PAYMENT POLICY ACKNOWLEDGEMENT

FINANCIAL AGREEMENT

We are committed to providing you with the best possible dental care. Our fees are representative of the usual and customary charges for our area. If you have dental insurance, we assist you in any way we reasonable can to help get your claims paid. In order to achieve these goals we need your assistance and your understanding of our payment policy.

It is important that you realize, however, that…

1. Your dental benefit contract is between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a ***courtesy to you***, but it is not obligated to do so. Regardless, you agree to pay any services that are not covered by your insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with your insurance plan requirements.
2. Proof of insurance. All patients must complete our patient information form. We must obtain a copy of your current, valid insurance card and a driver's license.
3. Insurance companies require the date of birth ***and*** social security number of the subscriber. Please make sure that information is listed on your patient history form.
4. Not all dental services are a covered benefit in all contracts.
5. You (not the insurance company) are responsible to us for all of our fees for services rendered to you.
6. For patients who have insurance an ***ESTIMATE*** will be given of the benefits that the insurance company is expected to pay, and any estimate is expected at the time services are rendered.

For the convenience of our patient, we offer the following methods of payment:

- Payment in full by cash, check, bank card or alternate financing for each appointment as service is rendered.
- For insurance patients we will accept payment for the initial examination directly from the insurance company for that percentage the company will cover. We gladly accept insurance assignments, but require that the deductible and non- covered fees be paid at each visit. In the event of a duplicate payment, you will be reimbursed or your account credited.
- Bank charge cards - Visa, Discover & MasterCard are accepted.
- Alternate financing (CareCredit) accounts are gladly accepted. We will be glad to assist you in filling out an application. Credit approval is required.
- Major services: Appliances, crowns, bridge partials and dentures. Payment of ½ at the initial appointment and the balance ***must be paid in full upon delivery.***

Southwest Dental Group, Robert D. Schick, D.D.S.
1007 West Oak Ave, Duncan, OK 73533
580-255-6621

Non-Payment

If your account is 90 days past due, you will receive a letter stating you have ***10 days to pay your account in full.*** Partial payments will not be accepted unless otherwise negotiated. Please be aware if a balance remains unpaid, we may refer your account to a collection agency and/or report to the credit bureau. You and your immediate family member may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternate dental care. During that 30 day period, our dentist will only be able to treat you on an emergency basis.

**Please be aware that any parent bringing a child to our office is legally responsible for payment of ALL services rendered.*

Missed Appointments

****Please give 24 hours notice of cancellation or charges may be your responsibility.****

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

I, the undersigned, as the patient or legal agent of the patient, hereby certify that I have read, and fully and completely understand the payment policy acknowledgement for dental treatment and that I have signed the payment policy acknowledgement knowingly, freely, voluntarily and agree to be bound by its terms.

Patient/Authorized Representative Signature: X_____ Date: _____ Relationship to patient: _____	Witness Signature and Title: X_____ Additional Witness Signature and Title: _____ (Patient was unable to sign or refused to sign)

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