Name: _____ Date: _____

Nickname: _____ SSN: _____

Date of Birth: _____ Marital Status: _____

Residence: _____

_____

Home #:_____ Cell #:_____

Occupation: _____ Work #:_____

Email Address: _____

Person Responsible for Account: _____

Who referred you to us? _____

Insurance Information

Policy Holder's Name: _____Date of Birth: _____

Relationship to Patient: _____

Insurance Company: _____ ID #:_____

Employer:_____ Group #:_____

Pharmacy Information

Preferred Pharmacy: _____

Phone #: _____ Location: _____

Dental Health Questions

What prompted you to seek dental care at this time?

_____

When was your last dental checkup and cleaning?

_____

How frequently do you get your checkups? _____

Does fear or discomfort kept you from regular dental visits? _____

Are you satisfied with your past dentistry? _____

How often do you brush? _____ Floss? _____

Are you troubled with bad breath? _____

Do your gums bleed easily, or feel tender? _____

Are your teeth sensitive to hot, cold, or sweets?

_____

Do you frequently snack between meals? _____

Are you self-conscious about the appearance of your teeth? _____

Would you like to retain your healthy natural teeth as long as possible? _____

Do you snore when you sleep? _____

Do others wake you up from sleeping because you're snoring? _____

Does your jaw feel tired? _____

Do you have frequent headaches or pain in neck, shoulders, or back?

_____

Are you aware of grinding or clenching your teeth? _____

Name of your previous dentist: _____

May we request previous dental records to facilitate proper treatment? _____

Anything else you want us to know about your dental history?

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. This includes Doctor Referrals, and sending or obtaining dental or medical records.
- Obtain payment from third-party payers. (Filing insurance)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____ Date_____

Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Authorization:

I authorize the use and disclosure of my photographic/video images, and/or testimonial for marketing purposes by Dr. Fling and Dr. Cord. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:

The photographic/video images, and/or testimonial will be used for: Seminars, Social Media, and/or Advertising

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroavtice. This authorization expires 99 years from date signed.

No Treatment Conditions:

I understand that the pracitce cannot condition treatment on whether or not I sign this authorization.

Signature _____ Date_____

Financial Policy & Dental Insurance

Each individual's treatment needs are unique. Because of the level of care we provide, we do not participate in plans where an insurance company dictates our fees. Before treatment is initiated, the estimated expense will be reviewed. Once a fee has been determined, our staff will consult with you regarding financial arrangements. We accept cash, checks, Visa, MasterCard, American Express and Discover cards.

Although we are not a party to the contractual arrangement with your insurance company, we do want to help you receive the maximum reimbursement to which you are entitled. As a courtesy to you we will help you process your insurance claims in order for you to receive this maximum benefit. We will also gladly provide dental x-rays and a written diagnostic report should your insurance company have any questions about the services provided.

I understand that Dr. Fling and Dr. Cord are not an "in-network" provider and that I am responsible for any expenses beyond what insurance may pay. After 100 days (unless arrangements have been approved) I understand that any unpaid balance to Dr. Fling and Dr. Cord will be turned over to American Profit Recovery.

Signature _____ Date_____

Cancellation Policy

It has always been our contention that your time is as valuable as ours. Our philosophy on scheduling is that during your appointment, you deserve our undivided attention. That is why maintaining appointments on time and honoring the schedule is so important for everyone. Unforeseen circumstances and emergencies can affect our schedule too, no doubt, these factors will be considered. Keeping those considerations in mind we are striving to preserve appointment times that honor both our patients and our practice. For these reasons, we will apply a $65 fee if a cancellation is made without 24-hour work day notice or if an appointment is no-showed. We look forward to your effort and understanding and we appreciate the confidence you place in our team.

Signature_____ Date_____

Permission for Contact

OKC Dental Arts has my permission to disclose information about my appointments and dental records in case of emergencies to the name(s) listed below.

Name: _____ Relationship to Patient:_____ #:_____

Name: _____ Relationship to Patient:_____ #:_____