Acquaintance Form & Health History

Date _____

Patient's Name _____ Marital Status _____

Nickname, if preferred _____ Spouse's Name (if married) _____

Date of Birth _____

Residence _____
Street address City Zip

Home Phone _____ Cell # _____ Employer _____

Position or Occupation _____ Length of Employment _____

Business Phone _____ Business Address_____

Emergency Name & Phone No._____

Person Responsible for Account _____

Referred by _____

Dental Insurance Yes ___ No ___ ** If yes, please present card to receptionist

If someone other than you is the policy holder, please list that person's date of birth_____

Social Security No. _____
Policyholder's Social Security No. _____

1.) What prompted you to seek dental care at this time? _____

2.) Date of your last thorough dental examination & cleaning? _____

3.) How frequently do you have your teeth examined? _____ cleaned? _____
x-rayed? _____

4.) Has fear of discomfort kept you from regular dental visits? _____

5.) Are you satisfied with your past dentistry? _____

6.) How often do you brush your teeth? _____ Dental Floss? _____

7.) Are you troubled with bad breath? _____

8.) Do your gums bleed easily, or feel tender? _____

9.) Are your teeth sensitive to hot, cold, or sweets? _____

10.) Do you frequently snack between meals? _____

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

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

13.) Do you snore when you sleep? _____

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

15.) Do your jaws feel tired? _____

16.) Do you have pain, frequent headaches or pain in neck, shoulders, or back?
_____

17.) Do you have clicking or popping noises when opening or closing your mouth?
_____

18.) Are you aware of grinding or clenching your teeth? _____

19.) Name of your previous dentist: _____

20.) May we request your previous dental records to facilitate proper treatment in our office? _____

21.) Would you like to receive correspondence via e-mail? Yes ___ No ___

E-mail address _____

Michael C. Fling, D.D.S.
6321 NW 63rd St., Suite D
Oklahoma City, OK 73116

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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: _____

If the patient is a minor, parent or guardian signature:

_____

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. We get it. Things happen. Flat tires, sick children and family emergencies can affect your schedule. Unforeseen circumstances and emergencies can affect our schedule too. No doubt, all of these factors have to be taken into account and we will most definitely do just that. Keeping those considerations in mind we are striving to preserve appointment times that honor both our patients and our practice. By doing so, we can be more responsible to our patients, our energy and to our overhead. This in turn reduces expenses that then keep fees from rising unnecessarily. For these reasons, we will apply a $65 fee if a cancellation is made without 48-hour work day notice or if an appointment is no-showed. No doubt, circumstances arise that may prohibit that notice. Every reasonable consideration will be given. We look forward to your effort and understanding and we appreciate the confidence you place in our team.

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.

At all times, you can be confident that we will always provide you with appropriate services without regard to the limitations imposed by your insurance coverage. To do otherwise would violate our contract with you – a contract we feel morally obliged to honor.

I understand that Dr. Fling is 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 and signed) I understand that any unpaid balance to Dr. Fling will be turned over to American Profit Recovery.

Signature _____ Date_____

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

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protexted 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.

If desired, copy provided:

- "Yes, I would like a copy of this form."
  (Initialed by team member, copy provided by _____)

Patient Name: _____
Date: _____

Signature: _____

If Personal Representative
Name: _____
Date: _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor

Parent/Legal Guardian: _____
Date: _____

Signature: _____