GREEN COUNTRY
DENTAL ARTS

Date: _____ File #: _____ SS# _____

PATIENT INFORMATION

Name: _____ Birthdate: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

E-mail: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ How Long? _____ Referred by? _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Spouse's Name: _____ Do you have children? How many? _____

INSURANCE INFO

PRIMARY DENTAL INSURANCE

Co. Name: _____ Phone #: _____ Insured's Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured ID#: _____ Group #: (Plan, Local, or Policy #) _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

SECONDARY DENTAL INSURANCE

Co. Name: _____ Phone #: _____ Insured's Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured ID#: _____ Group #: (Plan, Local, or Policy #) _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

ACCOUNT INFO

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____ Insured's Employer: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Drives License #: _____

Work Phone #: _____ Payment Method: ☐ Cash ☐ Check

_____ ☐ Credit Card - Enter card # about (if accepted)

_____ Initials

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

IN EVENT OF EMERGENCY

Whom should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Who is your Medical Doctor? _____ Medical Doctor's Phone #: _____

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DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ No ☐ Yes For how long? _____

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw
☐ Red, swollen or bleeding gums
☐ Sensitive tooth, teeth or gums
☐ Blisters/Sores in or around the mouth
☐ Other: _____
☐ Lost/Broken Filling(s)
☐ Teeth grinding
☐ Ringing in Ears
☐ Broken/Chipped tooth
☐ Stained teeth
☐ Locking jaw
☐ Bad breath

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

Previous Dentist: _____ Phone: _____

Last Dental Exam: _____ Last Dental X-rays: _____

Times a day you brush/floss? _____

What type of too th brush bristles do you use?

☐ Soft ☐ Medium ☐ Hard

How would you rate your smile?

(Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking?

☐ Nerve pills
☐ Stimulants
☐ Insulin
☐ Pain Killers (including aspirin)
☐ Blood Thinners
☐ Meds for Osteoporosis
☐ Muscle Relaxers
☐ Tranquilizers
☐ Others(s) _____

Have you ever taken Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

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

Y N Heart Attack/Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg/Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** X-Ray or Cobalt Treatment
Y N Heart Murmer	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Foods: _____ ☐ Others: _____

Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ☐ Yes ☐ No

For Women: Are you taking Birth Control Pills? ☐ Yes ☐ No How many children have you had? _____

Are you pregnant? ☐ No ☐ Yes/How long? _____ Are you nursing? ☐ Yes ☐ 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 arragnements 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.

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

Signature _____ **Date** _____

☐ ADULT PATIENT ☐ PATIENT/GUARDIAN ☐ SPOUSE

UPDATE
OFFICE USE

Initials _____ Date _____
Comment _____

Initials _____ Date _____
Comment _____

Initials _____ Date _____
Comment _____

GREEN COUNTRY
DENTAL ARTS

18020 SE Washington Boulevard
Bartlesville, OK 74006
918-336-1030

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgment. I have received a copy of Green Country Dental Arts' Notice of Privacy Practices. This acknowledgment of receipt will remain in effect until terminated by me in writing.

_____

Please Print Name

_____

Signature

_____

Date

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual Refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other