ACQUAINTANCE RECORD

We welcome you and your family into our practice. Please complete this form as thoroughly as possible. Thank you!

Mr. / Mrs. / Miss / Ms. / Dr. / Rev.

Patient's Name____ Nickname __________________ Sex M / F

Age_________ Date of Birth___________________________________ SSN___________________________________

DL # _____________________________ E-Mail ____
(for appointment Confirmations)

Address____
(city) (state) (zip)

Cell Phone__________________________ Home Phone______________________ Work Phone______________________

Name of Employer (School if full time student) ____

Marital Status: Single / Married / Divorced / Widowed / Separated / Partnered

Name of Spouse/Significant Other__________________________________ DOB____________________ Age_______

Spouse's Employer____________________________ Cell Phone_________________ SSN_________________________

In Case of Emergency-Contact_____________________________________ Phone Number________________________

Nearest Relative Not Living with you _______________________________ Phone Number_______________________

Whom may we thank for referring you to our office? ____

IF PATIENT IS A CHILD (UNDER 18 YEARS OLD OR COLLEGE STUDENT) PLEASE COMPLETE FOLLOWING SECTION:

Lives with Mother / Father / Both / Other____

Father's Name_______________________________ DOB____________________SSN______________________________

Address____ DL # ____________________
(city, state, zip code)

Cell Phone_________________________ Home Phone______________________ Work Phone_______________________

Employer's Name and Address____

Mother's Name_______________________________ DOB __________________ SSN_____________________________

Address____ DL # ____________________
(city, state, zip code)

Cell Phone_________________________ Home Phone______________________ Work Phone_______________________

Employer's Name and Address____

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR FULL PAYMENT AND THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

RESPONSIBLE PARTY'S SIGNATURE____ DATE__________________________

MEDICAL HISTORY

PATIENT NAME ________________________________

Name of Physician: Dr.____________________________ City/State _____________________ Phone #________________
Have You Had Any **Allergic Reactions** or Adverse Reaction, To Any Medications? **Y / N** Please List:
____
____
Please List **ALL Medications** You Are Taking and Why (Including Over-the-Counter and Herbal):
____
____
____
Do You Use Any Recreational or Medicinal Marijuana **Y / N** ____
____

Have You Ever Had or Presently Have?

Heart Disease/Attack/Surgery	**Y/N**	Ulcers	**Y/N**	Hepatitis	**Y/N**
Heart Murmur	**Y/N**	Diabetes	**Y/N**	HIV or AIDS	**Y/N**
Mitral Valve Prolapse	**Y/N**	Thyroid Problems	**Y/N**	Hemophilia	**Y/N**
Artificial Heart Valve or Stent	**Y/N**	Emphysema	**Y/N**	Liver Disease	**Y/N**
Stroke	**Y/N**	Asthma	**Y/N**	Epilepsy or Seizures	**Y/N**
Cancer	**Y/N**	Latex Sensitivity	**Y/N**	Psychological Care	**Y/N**
Artificial Joints	**Y/N**	Allergies	**Y/N**	Kidney Trouble	**Y/N**
Tuberculosis	**Y/N**	Radiation/Chemo	**Y/N**	High Blood Pressure	**Y/N**

Any Other Disease, Medical Conditions or Problems Not Listed?
____
____
____
____
____
Have You Ever Been Told You Should Pre-medicate with Antibiotics Prior to Dental Treatment? **Y / N**
____
Preferred Pharmacy? Name _________________________________ Phone #_____________________________________

Do You Smoke or Use Tobacco in Any Form? **Y / N** If so, For How Long and How Often? ____________________________

Women: Are you Pregnant? **Y / N** ____ months, Nursing? **Y / N** Take Birth Control Medication? **Y / N** ___________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient / Guardian Signature ____ Date________________________

DENTAL HISTORY

PATIENT NAME ____

Name of Previous Dentist: Dr. _____________________________________ City/State ____________________________
Approximate Date of Your Last Visit and what was done: ____
Why Have You Left Previous Dental Office? ____
Have You & Your Previous Dentists Ever Developed a 'Comprehensive Plan' to Get Your Mouth Healthy and Keep It Healthy? **Y /N** ____

Have You Ever Had:
- Orthodontics/Braces/Invisalign **Y / N** Age? ____
- Oral Surgery **Y / N** Age? ____________ Why? _______________________________________
- Gum Treatment **Y / N** When & Where? ____
- Implants **Y / N** When & Where? ____
- Denture or Partial? **Y / N** When? ____
- TMJ Treatment or Night Guard? **Y / N** ____

PRESENT DENTAL HISTORY

Are you having Dental Pain Now? **Y / N** Where? Please describe:
____
Any Sensitivity to Hot? **Y / N** to Cold? **Y / N** to Biting? **Y / N** to Sweets? **Y / N** Other? ___________________
Are you missing any teeth? **Y / N** If so, Where? ____
Do your gums bleed when brushing? **Y / N** Does food become caught between your teeth? **Y / N Where**? _____________
Do you notice Jaw clicking/popping? **Y / N** how often do you have headaches? __________________________________
On a scale 1-10 ("1" meaning Not Nervous & "10" meaning Very Nervous), how would you rate your feeling for having dental procedures performed on you____

FUTURE DENTAL OPTIONS

Are You Satisfied with the Appearance of Your Smile? **Y / N** If Not, What Would You Like to Change?
____
Do You Have Any Interest in?
Replacing Older Silver Mercury Fillings with White Composites? **Y / N**____
1-Appointment Crowns using CEREC Technology? **Y / N**____
Correcting Misaligned Teeth with Clear *Invisalign or Invisalign Teen*? **Y / N** __________________________________
Implants to Replace Missing Teeth? **Y / N** ____
Whitening Your Teeth? **Y / N** ____
Treatment for Canker Sores / Fever Blisters / Gum Disease using Laser Technology? **Y / N** ______________________
Cosmetic Porcelain Veneers / Inlays / Onlays / Crowns? **Y / N** ____
Nitrous Oxide ('*laughing gas*') – to help you relax through your dental treatment? **Y / N** ________________________
Sealants – preventive procedures which are totally painless and simple to apply? **Y / N** __________________________
Is There Anything Else about Your Dental Treatment That You Would like Us to Know? **Y / N** ______________________
____
____

Patient / Guardian Signature ____ Date ______________________

CONSENT FOR TREATMENT AND FINANCIAL POLICY

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF INSURANCE BENEFITS

I authorize Dr. Cary or staff to submit claims for payment for services to the health care services plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits. Further, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. **I understand that neither Dr. Jacob Cary nor his team members are responsible for my insurance coverage, nor for ensuring their payment(s) for my treatment.** Any BALANCE remaining due to underpayment or lack of payment by my insurance company will be my responsibility to pay in full.

Patient/Guardian: ____ DOB: ____

SS # ____ DL #____

DENTAL INSURANCE INFORMATION

Name **of Primary Insurance Holder** ____
Relation to Patient ____
SSN____ EmployerName____
Group Number ________________________________ Dental Insurance Phone Number ______________________________________
Dental Insurance Company & Address ____

Name of **Secondary Insurance Holder** (if applicable) ____
Relation to Patient ____
SSN______________________________ Employer Name____
Group Number ____________________________________ Dental Insurance Phone Number ___________________________________
Dental Insurance Company & Address ____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Dr. Cary or staff to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, or association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall remain effective until revoked by this office in writing. I know that I have the right to receive a copy of this authorization if requested

CONSENT TO TREATMENT PLEASE INITIAL 1-6 BELOW

1._____ I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, diagnose laser and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (the patient named below) dental needs.

2._____ upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3._____ I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4._____ I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless prior arrangements have been made. In order to obtain extended financial arrangements, I agree to allow my in-office payment history to be examined. In the event payments are not received by agreed upon dates, I understand that a delinquent payment charge of $10.00 will be assessed each month a payment is delinquent. I also understand that my account may be assessed a service charge of 1-3/4% (21%APR) for balances older than 90 days. I am aware, should my account be in default or "collections", a collection fee of up to 33% of the balance will be added. I also understand an insufficient funds charge of $35 may be added to my account for any returned payments. I am aware that payments may be made with cash, check, VISA, MasterCard, Discover or American Express. I also realize that 3rd party credit is possible, such as Care Credit, and that Dr. Cary is not responsible for their administration. I am aware that my records will not be released until a zero (0) balance is on the account.

5._____ I am aware that there will be a $50 broken appointment fee for any missed or canceled appointments with less than 48 hours' notice, following 3 or more broken appointments.

6._____ In the event of financial arrangements or payments by phone; I hereby authorize Jacob Cary DDS to retain this signed form, with my signature on file, and charge the agreed amount to my charge card.

Print Patient Name: ____ **Date**: ___________________________

Patient / Guardian **Signature**: ______________________________________ ______________________________
(Relationship to patient)

Staff Initials: ___________

Jacob Cary, DDS
8500 N 129th E Ave, Owasso, OK 74055-7168
(918) 274-8500
(918) 274-8522 fax
info@lexingtondentalofowasso.com

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 obtain payment from third-party payers
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 his 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____ Date: _________________
Patient *Signature*: ____ Relationship to Patient: _____________

I give permission to the following individuals to access my records and to discuss my records with Dr. Cary or any of our staff:

____
____
____

Signature: ____ *Date:* ______________________

Office Use Only Below
Please state below that this office did attempt to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as stated below:

____
____

Staff Initials _________ *Date:* ______________________________

Appointment Cancellation Policy

At Jacob Cary, DDS we strive to have timely appointments available for patients that need to be seen quickly. Therefore, **we request that our patients notify the office as soon as possible if you will be unable to keep your scheduled appointment.** We certainly appreciate that emergencies such as illness, etc., do occur and remain sensitive to the challenges of everyday life.

We also feel that it is important to emphasize the importance of timely communication that benefits all our patients. With timely notification of a schedule change, we reserve the opportunity to give another patient an appointment when he/she needs it most.

Finally, just as we wish to build a practice culture of generous self-care from a dental perspective, we are also committed to creating a culture of timeliness and courtesy so that our patients can juggle life's commitments with minimal inconvenience.

In support of these goals, we have documented the existing Appointment Cancellation Policy, which is the model commonly used by most dental practices in the area, as follows:

There may be a **$50 fee assessed for an appointment missed or cancelled less than 48 hours in advance.**

We absolutely appreciate your commitment to your dental health and your trust in us as a practice! If you have any questions at all about this policy, please do not hesitate to ask.

I have *read the above information regarding the Appointment Cancellation Policy and agree to its terms.*

Name (please Print): ____

Signature: ____ Date: ______________________

8500 N 129TH E Ave · Owasso, OK · (918) 274-8500 · Fax (918) 274-8522 · info@lexingtondentalofowasso.com