Oak Tree Dentistry

Sean Carr DDS Hillary Frey DDS

Adult General & Cosmetic Dentistry

PATIENT INFORMATION SHEET

Date: _____

Last Name: _____ First Name: _____ MI: _____

What Name/Nickname Do you use? _____ Sex: _____

Marital Status: Single Married Divorce Date of Birth: _____

SSN: _____ **Whom may we thank for referring you to our office?** _____

LOCAL ADDRESS:

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Tel: _____ Cell Phone: _____

Email: _____ Preferred Contact Method: _____

PERMANENT ADDRESS: if different from

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Tel: _____

IF THE PATIENT IS A MINOR:

Mother/Father's Name: _____

EMERGENCY INFORMATION: Person to Contact in Case of Emergency

Name: _____ Phone: _____

FINANCIAL POLICY:

Payment is expected in full at each appointment. We accept cash, personal checks, Visa, MasterCard, American Express, and Apple Pay. A copy of your driver's license is required for proper identification. If you have dental insurance, and after your insurance benefits are verified, you will be responsible for all deductibles and estimated co-payments at the time of services rendered.

Any treatment involving laboratory fees (crowns, bridge, partials, dentures, etc.) must be paid as follows: ½ of the total fee at the initial treatment visit, and the remaining ½ at the completion of treatment.

I have read and understand the financial policy of this office.

Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____

Physician: _____ **Phone**: _____

1. Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐
   For what? _____
2. Have you been hospitalized during the past two years? Yes ☐ No ☐
   For what? _____
3. Are you now taking any medication or drugs, including aspirin? Yes ☐ No ☐
   For what? _____
4. Are you allergic to any drugs or materials (for example penicillin, metals, latex, etc.)? Yes ☐ No ☐
   If so, which? _____
5. Have you ever had major surgery? Yes ☐ No ☐
   For what and when? _____
6. Please check any of the following, which you have had or have at present:

☐ Heart attack / Surgery	☐ Arthritis	☐ Rheumatic fever
☐ Artificial heart valve	☐ Emphysema	☐ Epilepsy / Seizures
☐ Angina	☐ Artificial joints	☐ Diabetes
☐ HBP	☐ Sinus problems	☐ Smoker / Tobacco use
☐ Stroke	☐ TMD / Joint pain	☐ Drug / Alcohol use
☐ Heart Murmur / MVP	☐ Osteoporosis	☐ Thyroid Disease
☐ Congenital heart disorder		☐ Hepatitis
☐ Pacemaker		☐ Kidney disease
☐ Anemia		☐ Cancer Treatment / History
☐ TB / HIV / AIDS		

Other blood disorders: _____

WOMEN: Are you pregnant or nursing? Yes ☐ No ☐

Are you taking oral contraceptives? Yes ☐ No ☐

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. If there are any changes in my medical status, or if medicines change, I will inform the dentist as soon as possible. By signing this form, I acknowledge that I have read it completely and understand its contents.

Signature of Patient, Parent or Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Medical Updates

_____ Date: _____

_____ Date: _____

_____ Date: _____

DENTAL HISTORY

Patient Name: _____ **Date:** _____

What is your main dental problem or the purpose of this visit?

_____

Date of your last dental visit and reason?

_____

	Yes	**No**
Do you have copies or access to any recent X-rays or dental records?	☐	☐
In respect to any previous dental treatment:	**Yes**	**No**
Have you ever had an allergic reaction?	☐	☐
Have you ever had any complications during or following dental treatments?	☐	☐
Have you ever been told you have gum disease?	☐	☐
Have you been told you need antibiotics before dental treatment?	☐	☐
Do your gums bleed on brushing or flossing?	☐	☐
Are any of your teeth sensitive to heat, cold, or pressure?	☐	☐
Do you grind your teeth or clench your jaw?	☐	☐
Do you have pain or clicking in the jaw joints?	☐	☐
Do you regularly have soreness in your jaw muscles?	☐	☐
Are there any sores or growths in your mouth now?	☐	☐
Do you want whiter teeth?	☐	☐
Are you happy with the appearance of your smile?	☐	☐
Do you have problems with bad breath?	☐	☐

Is there anything else that you think we should know about your care and treatment in this office?

Explain:

_____

_____

_____

_____

NOTICE OF PRIVACY / CONSENT FORM HIPAA

PATIENT GIVING CONSENT
PRINT NAME: _____

Notice of Privacy Practices: You have the right to review our Notice of Privacy Practices before signing. We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. You may obtain a revised copy if we change our notice by contacting our Practice Administrator.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We may use and disclose health information to call your home or other contact information to remind you of an appointment or that it is time to make an appointment at this office. You have the right to revoke this consent, in writing, signed by you, at any time. However, such revocation shall not affect any disclosure we may already have made in reliance on your prior consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

1. **Information may be disclosed to other providers who may be involved in your continuing care and course of treatment directly and indirectly.**
2. **Information may be disclosed to obtain reimbursement from your insurance company that we have on file for payment to the provider or yourself for services rendered.**
3. **Information may be disclosed for all billing and collection activities.**
4. **We may contact you at your home or via other contact information you provided us with to confirm your appointment or discuss treatment-related information with you.**

***The practice may condition rendering of treatment upon the execution of this consent.**

CONSENT TO DENTAL PHOTOGRAPHY

By consenting to release my dental photographs and/or audio/video, I understand that I will not receive payment from any party. Although these photographs, videos, or audio will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs or videos will in no way affect the dental care that I will receive.

I authorize the use of these images:

- For Dental Records, Research, and Education including lectures seminars, demonstrations, and professional publications such as journals or books
- For our website, professional journal, and/or advertisement purposes or social media accounts (examples: Facebook, Instagram, Twitter, etc...)
- I give my consent for ONLY non-identifying photos taken ☐

I give/give not consent to Oak Tree Dentistry to use any media. **Give Consent** ☐ **Do Not Give Consent** ☐

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following…

Personal Representative Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION

Is the patient covered by Dental Insurance? **Yes** ☐ **No** ☐

If yes, please provide our receptionist with your Drivers License and all Dental Insurance Cards so a copy can be included in the chart, as insurance companies require proof of identification.

INFORMATION ABOUT INSURED

Last Name: _____ First Name: _____ MI: _____

SSN: _____ Date of Birth: _____ Relation to: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

If you have Dental Insurance Coverage and are an established patient in this office:

After your insurance benefits are verified, and as an added service to our patients, we will submit your insurance claims for you, and accept assignments of your balance from your **primary insurance carrier only**. We do not get involved with secondary insurance companies or Cobra plans; this is your responsibility. You will be responsible for all deductibles and estimated co-payments at the time services are rendered. Some insurance companies have an undisclosed fee schedule or will only reimburse the insured and **NOT** the provider. In these cases, payment is expected in full, and you will get reimbursed from your insurance company.

I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the dentist; therefore, my insurance company may pay less than the actual bill of services and I am still responsible for all dental fees incurred.

Permission to Release Health Information and Assignment of Benefits to Dentist. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third-party payers (and-or other health practitioners) and I authorize payment of any Insurance benefits to Sean P. Carr, DDS, and Hillary Frey, DDS.

Signature: _____ Date: _____

If Patient is a Minor:
Parent's Signature: _____ Date: _____

Permission to Release Health Information Only:
I grant the rights to release health information obtained from me, and information about my dental treatment to third-party payers (and-or other health practitioners).

Signature: _____ Date: _____

If Patient is a Minor:
Parent's Signature: _____ Date: _____