



EL RENO FAMILY DENTISTRY
GENERAL COSMETIC IMPLANT SEDATION™

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Welcome to El Reno Family Dentistry.

We are so honored you have chosen our dental team to take care of you! We strive daily to be the leading team in dentistry. Therefore, we are committed to providing a warm, caring, and professional environment for our patients. **We are El Reno's Most Caring Dental Office™.**

At El Reno Family Dentistry, we believe that it's our attention to detail that sets us apart from other dental care providers. Every day we strive to put our patients first by starting our appointments on time and treating everyone like family. We partner with you to provide superior general, cosmetic, implant, and sedation dental services for the entire family. We believe in **total wellness** so please talk to us about your health, including but not limited to teeth and gum concerns, headaches, fatigue, and any dental hygiene questions you may have for you or your family.

We want to encourage more people to take care of their dental health. Recent statistics indicate that a little over half of the people in Oklahoma go to a dentist regularly. That is why we offer a **FREE First Visit™**. This includes an exam with the doctor and x-rays. Please tell your friends about this program.

We invite you to ask questions because we want to create a lifelong relationship with you. We are very proud to be part of this community and we thank you for being here today!

PATIENT REGISTRATION

Today's Date _____

Patient's Name _____ Sex: M F _____ Birthdate _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Please Circle One: Single Married _____ Your Soc. Sec. # _____

Home Ph. # _____ Cell Ph. # _____ E-mail Address _____

Your Employer _____ Work Ph. # _____ How Long Employed _____

Are you a full time student? Yes No If so, where? _____

If patient is minor, we need: _____ Mother's DOB _____ Father's DOB _____

Person responsible for account _____ DOB _____ SSN # _____ Relationship _____

Name of spouse (parent if minor) _____ Spouse's (parent's) Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Spouse's (parent's) Employer _____ Work Ph. # _____ Cell Ph. # _____

EMERGENCY INFORMATION

Name, address & telephone of a relative not living with you. _____

Dental concerns you wish to discuss today? _____

How did you hear about our office? Sign Facebook Website Mail Advertisement Google Referral
 If referral, please let us know who we can thank. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)	
Insured's Name	Relationship to Patient
Insured's Employer	
Insurance Co.	
Insurance Co. Address	
Phone #	DOB
SS#/Member ID #	Group #

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician / and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

YES NO

YES NO

1. hospitalization of illness or injury _____

2. an allergic reaction to _____

aspirin, ibuprofen, acetaminophen, codeine

penicillin

erythromycin

tetracycline

sulfa

local anesthetic

fluoride

metals (nickel, gold, silver, _____)

latex

other _____

3. heart problems or cardiac stent within the last six months _____

4. history of infective endocarditis _____

5. artificial heart valve, repaired heart defect (PFO) _____

6. pacemaker or implantable defibrillator _____

7. artificial prosthesis (heart valve or joints) _____

8. rheumatic or scarlet fever _____

9. high or low blood pressure _____

10. a stroke (taking blood thinners) _____

11. anemia or other blood disorder _____

12. prolonged bleeding due to a slight cut (INR>3.5) _____

13. emphysema, shortness of breath, sarcoidosis _____

14. tuberculosis, measles, chicken pox _____

15. asthma _____

16. breathing or sleep disorders (i.e. sleep apnea, snoring, sinus) _____

17. kidney disease _____

18. liver disease _____

19. jaundice _____

20. thyroid, parathyroid disease, or calcium deficiency _____

21. hormone deficiency _____

22. high cholesterol or taking statin drugs _____

23. diabetes (HbA1c= _____) _____

24. stomach or duodenal cancer _____

25. digestive disorders (i.e. celiac disease, gastric reflux) _____

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____

27. arthritis, rheumatoid arthritis, lupus _____

28. glaucoma _____

29. contact lenses _____

30. head or neck injuries _____

31. epilepsy, convulsions, (seizures) _____

32. neurologic disorders (ADD, ADHD, prion disease) _____

33. viral infections and cold sores _____

34. any lumps or swelling in the mouth _____

35. hives, skin rash, hay fever _____

36. STI/STD _____

37. hepatitis (type _____) _____

38. HIV / AIDS _____

39. tumor, abnormal growth _____

40. radiation therapy _____

41. chemotherapy, immunosuppressive _____

42. emotional problems _____

43. psychiatric treatment _____

44. antidepressant medication _____

45. alcohol / street drug use / medicinal marijuana _____

ARE YOU:

46. presently being treated for any other illness _____

47. aware of a change in your health in the last 24 hours _____

(i.e. fever, chills, new cough, or diarrhea) _____

48. taking medication for weight management (i.e. fen-phen) _____

49. taking dietary supplements _____

50. often exhausted or fatigued _____

51. experiencing frequent headaches _____

52. a smoker, smoked previously, or use smokeless tobacco _____

53. often unhappy or depressed _____

54. FEMALE - taking birth control _____

55. FEMALE - pregnant _____

56. MALE - prostate disorders _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

DRUG	PURPOSE	DRUG	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



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How do you like your smile?

Are you happy with the appearance of your smile? Yes No

Are your teeth straight? Yes No

Do you like the color of your teeth? Yes No

Do you like the shape of your teeth? Yes No

Do you have old fillings that you don't like? Yes No

What would you like to change most about the appearance of your teeth? _____

Do you have any concerns that you would like to share? _____

**Acknowledgment of Receipt of Notice of Privacy
Practices and HIPAA Non-Secure Communication
Consent Form**

Patient Name:	Date of Birth:

This consent form allows El Reno Family Dentistry to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

El Reno Family Dentistry has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at El Reno Family Dentistry.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that El Reno Family Dentistry may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that El Reno Family Dentistry may refuse service if I revoke this consent.

I understand that I have the right to request — now and in the future — how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while El Reno Family Dentistry is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor)/
Authorized Representative _____ Date: _____

I hereby authorize El Reno Family Dentistry to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Initial Information related to billing and payment.

I hereby authorize that El Reno Family Dentistry may leave messages on my voicemail to confirm appointments, and/or Initial speak with other members of my household and leave messages with them regarding my appointments.

___ Email ___ Home Phone ___ Office Phone ___ Cell Phone

I hereby authorize that El Reno Family Dentistry may disclose my health information to any person(s) who accompany Initial me to my appointment, and are present with me in the office while I meet with my dentist and staff.

I hereby authorize that El Reno Family Dentistry may disclose my personal health information to the person who I have Initial listed as my emergency contact.

I hereby authorize that El Reno Family Dentistry may disclose my personal health information to the following person(s). Initial

Name	Telephone Number	Relationship to Patient

CLIENT PHOTO RELEASE FORM

I, _____, hereby authorize El Reno Family Dentistry to take photographs, x-rays, intra oral pictures, slides and/or videos of my facial area, jaws, teeth or anything in reference to my dental treatment.

I understand that these diagnostic tools will be used as a record of my care and may be used for educational purposes in lectures, demonstrations and advertising. Their use may include, but are not limited to, website publication, newspapers, magazines, phone books, television and professional (dental magazines and journals), videos and social media.

I also understand that if the photographs, x-rays, intra oral pictures, slides and/or videos of my facial area, jaws, teeth or anything in reference to my dental treatment are used in any type of marketing publication or as part of any presentation or demonstration, that my name or other identifying information may be used unless otherwise stated below. I do not expect compensation, financial or otherwise, for the use of photographs. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

PLEASE INITIAL:

____ I do not mind if my name and face are used in any of the above mentioned situations.

EXCEPTIONS:

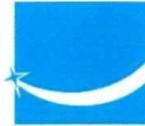
____ I do not wish to have my name shown or released.

____ I do not wish to have my face shown.

Signature: _____ Date: _____

If patient is a minor:
Parent/Legal Guardian: _____ Date: _____

Signature: _____ Date: _____



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Cancellation & No-Show Policy

We at El Reno Family Dentistry are here to take care of you, our patient. We appreciate you and understand your time is valuable which is why we make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. When a reserved appointment is missed, that time cannot be used to treat another patient. We reserve the right to charge patients who do not cancel with adequate notice or who fail to keep their scheduled appointments. To respect the needs of all El Reno Family Dentistry patients, if it is necessary to cancel your reserved appointment, we require that you contact our office **48 hours in advance**. Appointments are in high demand and your early cancellation will give another person the opportunity to access timely dental care.

A 'no-show' appointment occurs when a patient misses an appointment without cancelling 48 hours in advance. Missed appointments are an inconvenience to patients who need access to dental care in a timely manner; is inconsiderate to our doctor and team who are left sitting idle. Last minute/late cancellations are considered 'no-show' appointments. We reserve the right to charge for any appointment(s) broken without 48 hours notice. **The charge will be \$30 per scheduled appointment.** These fees are not covered by insurance and are the sole responsibility of the patient. Fees must be paid in full prior to the patient's next appointment. Habitual missed/cancelled/rescheduled appointments may result in a patient being required to either pay up front prior to scheduling an appointment or this office may no longer be available to provide dental services for the patient.

Our voice mail is available for messages left after business hours, however if a message is left after business hours cancelling an appointment for the next day this will be subject to our fee.

Our practice firmly believes that good doctor/patient relationship is based on trust and good communication. Questions about cancellation and no-show fees can be answered by our team.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient/Guardian Signature

Date