PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name: Last First Middle

Address: Street or P.O. Box # City State Zip code

Phone Number:
Home:
Work:

Pager#: Cell Phone: Email Address:

Age: Yrs. Birth Date: Mo. Day Year Birthplace:

( )Married
( )Unmarried
( )Separated

Social Security No: (if child, parents) Driver's License No:

Occupation: Employer: How long employed? Address & Phone No:

Person responsible for bill: Age: Address: Relationship: Social Security No:

Driver's License No:

Occupation: Employer: How long Employed?

Employer Address & Phone No:

Insurance Information

Insured Person's Full Name Date of Birth

Social Security Number Relationship to Patient Work Phone

Insurance Company Name Group or Union Name Group or Local Numbers

Employer's Name Full Address of Employer

Getting to Know You

1. Why did you select our practice? _____
2. Whom may we thank for referring you? _____
3. Is another member of your family or relative a patient in our practice? _____
4. Person to contact for emergency: _____ Phone: _____
5. When was your last dental visit? _____
6. When was the last time you had complete dental radiographs taken? _____
   Name and Address of last Dentist: _____
7. Have you ever had any teeth removed? _____
   How long have these teeth been missing? _____
   Have these teeth been replaced? _____
   How? ❒Bridge ❒Partial ❒Denture ❒Implants

Payment Alternatives

Please check appropriate box:

❒ 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.

❒ 2. Cash and personal checks are accepted as your treatments are provided.

❒ 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

❒ 4. Mastercard, Visa, Discover and American Express

❒ 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party Relationship Date

Lake Pointe Dental Group
10914 Hefner Pointe Drive, #150
Oklahoma City, OK

Dr. Shannon Maddox and Team

www.LPFDOKC.com
(405)946-5558

MEDICAL HISTORY

1. How do you feel about getting and maintaining a healthy mouth?_____
2. How do you feel about the appearance of your teeth?_____
3. If you could change anything about your smile, what would you change?_____
4. Are you having dental problems at this time?.....❒Yes ❒No
5. Do your gums bleed at any time?.....❒Yes ❒No
6. Do you feel very nervous about having dental treatment?.....❒Yes ❒No
7. Have you ever had a bad experience in the dental office?.....❒Yes ❒No
8. Have you been under the care of a medical doctor during the past two years?.....❒Yes ❒No
   If yes: for what reason?_____
   Please provide the name, address, and telephone number of your physician.
9. Have you been a patient in the hospital during the past two years?.....❒Yes ❒No
   If yes: for what reason?_____
10. Have you taken any medicine or drugs during the past two years? If yes, please list:.....❒Yes ❒No
11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:.....❒Yes ❒No
12. Have you ever had excessive bleeding requiring special treatment?.....❒Yes ❒No
13. Do you use any tobacco products?.....❒Yes ❒No
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?.....❒Yes ❒No
15. Do your ankles swell during the day?.....❒Yes ❒No
16. Have you lost or gained more than 10 pounds in the last year?.....❒Yes ❒No
17. Do you use more than 2 pillows to sleep?.....❒Yes ❒No
18. Do you ever wake up from sleep short of breath?.....❒Yes ❒No
19. Are you on a special diet?.....❒Yes ❒No
20. Check any of the following which apply in either past or present:

❒Heart Valve Prolapse	❒High Blood Pressure	❒Cortisone Medication
❒Heart Failure	❒Anemia	❒Arthritis
❒Heart Disease or Attack	❒Asthma	❒Pain in Jaw Joints
❒Family History of Cardiovascular Disease	❒Emphysema	❒X-Ray or Cobalt Treatment
❒Angina Pectoris (chest pain)	❒Shortness of Breath	❒Cancer or Tumors
❒Rheumatic Fever	❒Hay Fever	❒Chemotherapy (Cancer, Leukemia)
❒Congenital Heart Lesions	❒Allergies or Hives	❒Thyroid Disease
❒Scarlet Fever	❒Fainting or Dizzy Spells	❒Glaucoma
❒Artificial Heart Valve	❒Epilepsy or Seizures	❒HIV Positive (AIDS)
❒Heart Pacemaker	❒Nervousness	❒Venereal Disease
❒Heart Surgery	❒Psychiatric Treatment	❒Cold Sores or Fever Blisters
❒Artificial Joint of Any Type	❒Any Form of Eating Disorder	❒Genital Herpes
❒Diet Medication: Name_____	❒Recreational Drug Use	❒Kidney Trouble
❒Heart Murmur	❒Drug Addiction/Alcoholism	❒Diabetes
❒Bruise Easily	❒Tuberculosis (TB)	❒Ulcers
❒Blood Transfusion	❒Any Form of Hepatitis	❒Stroke
❒Hemophilia	❒Liver Disease	❒Birth Control Medication
❒Sickle Cell Disease	❒Rheumatism	❒Pregnant – Due Date_____

21. Do you have any disease, condition or problem not listed? If so, please list.....❒Yes ❒No

LAKE POINTE
DENTAL

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OKC, OK

Smile Evaluation

1. Do you like the way your teeth look? Yes _____ No _____
   Explain _____
2. Are you happy with the color of your teeth? Yes _____ No _____
   Explain _____
3. Would you like your teeth to be whiter? Yes _____ No _____
   Explain _____
4. Would you like your teeth to be straighter? Yes _____ No _____
   Explain _____
5. Do you have spaces between your teeth you would like closed?
   Yes _____ No _____
   If so , where ? _____
6. Would you like your teeth longer? Yes _____ No _____
   If so , Upper _____ Lower _____
7. Do you have missing teeth you would like replaced? Yes _____ No_____
   Explain _____
8. Do you like the shape of your teeth? Yes _____ No_____
   Explain _____
9. Do you have old silver fillings you would like replaced with tooth-colored fillings?
   Yes _____ No _____
   Explain _____
10. If you could change anything about your smile, what would you change?
    Explain _____
    _____

I agree to let Lake Pointe Dental team take photos of me to utilize for eduacational or promotional purposes.

Signature: _____

Date: _____

LAKE POINTE DENTAL

LAKE POINTE DENTAL

OKLAHOMA CITY, OKLAHOMA

VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

Review Date 08/2023

PATIENT NAME: _____

DATE OF BIRTH: _____

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree that Lake Pointe Dental and its duly authorized agents and employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to my family members, other relatives, close personal friends or any other individuals that I indicate below who may contact Lake Pointe Dental on my behalf.

NAME OF INDIVIDUAL(S) AND RELATIONSHIP: (Please print)
Check the box next to the name to identify the type of information to be disclosed.

☐ Dental
☐ Billing

☐ Dental
☐ Billing

☐ I do NOT want LAKE POINTE DENTAL to disclose information to anyone besides myself.

I understand:

- At any time, I may add or remove individuals from this list by notifying LAKE POINTE DENTAL of my desire to do so. I understand that until I notify LAKE POINTE DENTAL of requested changes to this list, LAKE POINTE DENTAL may rely on this list and disclose information the individuals listed above.
- FOR DENTAL - The permission granted in this form is for the current visit only and will expire at the time of discharge.
- FOR BILLING - The permission granted is valid until I have notified the facility to change the list and is valid for the current visit only. Permission expires at the time the current bill is paid in full.

Visitor: _____

Visitor: _____

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances *including* disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified. I understand that my medical information may indicate that I have or have not been treated for psychological or psychiatric conditions or substance abuse.

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE DATE

☐ Patient ☐ Parent of Minor ☐ Guardian ☐ Power of Attorney

DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

REVOCATION OF VERBAL DISCLOSURE

I may revoke this permission at any time, in writing, except revocation will not apply to information already disclosed in response to this permission.

Patient/Patient Representative Signature Date Revocation Signed

LAKE POINTE
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OKC, OK

Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Lake Pointe Dental Group's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please specify)**

_____

_____

_____

_____

To be retained in patient's file.

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Lake Pointe Dental Group and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anaesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants).
E. Removal (extraction) of one or more teeth.
F. Treatment of diseased or injured oral tissues (hard and/or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
I. Use of general anaesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that this risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anaesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgement of the dentist.

5. There are possible risks and complications associated with the administration of local anaesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that either are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instruction of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ **Time:** _____**AM/PM File No.** _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

Signature: Patient or Parent or Guardian _____

Witness: _____

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