Patient Information

Name: _____Date: _____ Date of Birth: _____
Patient Address: _____City/State:_____ Zip:_____
Primary Patient Phone #: _____ Email: _____
Social Security #: _____Employer: _____
Emergency Contact Name: _____Emergency Phone #: _____
Pharmacy Name: _____Pharmacy Phone #: _____
Dentist name: _____City:_____Date of Last Appt:_____

Preferred Method of Contact:

I wish to be contacted in the following manner (check all that apply):

__OK to leave message with detailed information.
__OK to leave message with callback information only.
__OK to send text message.
__OK to send email.
Alternate Phone Number:_____ Home__ Work__ Cell__

List any other person allowed to discuss your information. This includes emergency contacts or persons involved in financial discussions:

_____

***Your contact information will be used for necessary office correspondence regarding your appointments, treatment, or payments only. You will not receive any marketing information or unnecessary contact from us. We protect your personal information.**

Authorization

I certify that I have insurance coverage with _____ and assign directly to Implant Surgery Center, partnered with Oklahoma Family Dentistry, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Implant Surgery Center may use my health care information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the signed date below.

X_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

HIPAA- Acknowledgement of Receipt of Notice of Privacy Practices.

I have received a copy of Implant Surgery Center's Notice of Privacy Practices.

_____ _____
Please Print Patient Name Patient/Parent/Guardian Signature

I refuse to sign this acknowledgement. _____

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

_____

Medical History

Primary Care Physician's Name:_____ Date of Last Visit:_____

Physician's Location/Facility: _____

- Have you ever or are you currently using a bisphosphonate medication whether in tablet form, IV, or injection (common brand names are Fosamax, Actonel, Prolia, Zometa, Boniva)? **Yes No**
  If yes, please list medication, form taken, and date last used _____
- Are you currently taking any anticoagulants (blood thinner) or immunosuppressive drugs, including biologics? **Yes No**
- Have you had any serious illnesses or operations, including joint/valve replacements, organ transplants, history of endocarditis, or shunts? **Yes No** - If yes, describe and date:_____
- Have you had any radiation to your head or neck? **Yes No** - If yes, describe _____
- Have you had previous Jaw Pain or TMJ treatment? **Yes No** - If yes, describe _____
- Have you ever had a sleep study or been referred to have a sleep study by another provider? **Yes No**
- Do you have diabetes? **YES NO** – If yes, what type?_____ Date & results of last A1c:_____
- Do you have or have you ever had seizures? **Yes No** If yes, list date of last seizure & frequency._____
- Women - Are you pregnant? **Yes No**

Check X if you have or have had any of the following:

__Anemia	__Glaucoma	__Rheumatic Fever
__Arthritis, Rheumatism	__Illicit Drug Use	__Shortness of Breath
__Artificial Heart Valves	__Heart Murmur	__Sjogren's Syndrome
__Artificial Joints	__Heart Problems	__Sleep Apnea
__Blood Disease	__Hemophilia	CPAP - Y N
__Cancer	__Hepatitis___	__Tuberculosis
__Chemotherapy	__High Blood Pressure	__Ulcers
__Circulatory Problems	__HIV/AIDS	__Use of Medical or
__Cortisone Treatments	__Kidney Disease	Recreational Marijuana
__Diabetes	__Liver Disease	__Tobacco Habit
__Epilepsy	__Radiation Treatment	(smoking or vaping)
__Fainting	__Respiratory Disease	__Stroke

Medical Conditions Not Listed Above:_____

_____

MEDICATIONS that you are currently taking: _____

_____

_____

ALLERGIES: _____

_____

OTHER TREATING PHYSICIANS:

Name	Specialty	Location

X_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

_____ _____

Print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient