Blackwell Dentistry
1520 S Main St. Blackwell, Ok. 74631
580-363-0728 Fax: 855-313-5098

Contact Information

Patient Name_____ SSN_____ DOB ___/___/_____

Home phone _____ Work phone_____

Cell Phone _____

Mailing Address _____ Billing Address _____
_____ _____
_____ _____
_____ _____

Email Address:_____

Parent/Guardian contact name & number: _____
Parent/Guardian DOB: _____/_____/_____
Parent/Guardian SSN: _____
Parent/Guardian Employment: _____

Release of Medical Information to: _____

Do you have dental insurance? Yes/ No

Insurance Cardholder's name _____
DOB ___/___/_____ SSN _____
Place of Employment _____

What is the best way to contact you?: _____

How did you hear about us?

_____
_____
_____

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HEALTH QUESTIONNAIRE

Today's Date **Patient's Name** **Birthdate**

•___/___/_____ •_____ • ___/___/_____

• _____

(Name of person completing form (if different from patient) and relationship to patient.)

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information you provide will be kept confidential.

*****PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION.**

1. Are you in good health? …… Y N
2. Has there been any change in your general health in the past year? …… Y N
3. Date of last check up by physician: _____
4. Are you currently under a physician's care? …… Y N
   If so, what for? _____
   _____
   _____
   Treating Physician's name? _____Phone # _____
5. Have you had any serious illness, operations, or hospitalizations? …… Y N
   If so, describe and give approximate dates_____
   _____
   _____
   _____
6. Have you ever had intravenous sedation or general anesthesia? …… Y N
   Were there any adverse effects? …… Y N
7. Do you generally tolerate dental treatment well?…… Y N
8. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic fever or Rheumatic heart disease? …… Y N
   - B. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, stroke, palpitations, heart surgery, angioplasty, pacemaker)? …… Y N
   - C. High blood pressure?..... Y N
   - D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? …… Y N
   - D. Neurologic Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? …… Y N
   - E. Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? …… Y N
   - F. Liver Disease (jaundice, hepatitis)? …… Y N
   - G. Kidney Disease? …… Y N
   - H. Diabetes? …… Y N
   - I. Thyroid Disease (hypothyroidism, tumor)? …… Y N
   - J. Arthritis? (which joints?) _____ Y N
   - K. Stomach ulcers or Intestinal problems? …… Y N
   - L. Glaucoma? …… Y N
   - M. Frequent or recurring mouth sores? …… Y N
   - N. Implants/artificial joints anywhere in your body (Heart valve, hip, knee)?.. …… Y N
   - P. Radiation (X-Ray treatment for cancer) in head and neck region? …… Y N
   - Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? …… Y N
   - R. Sinus or nasal problems? …… Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system?…… Y N
   - T. Recurrent infections of any kind? …… Y N
9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:
   - A. Antibiotics? …… Y N
   - B. Anticoagulants (blood thinners)? …… Y N
   - C. Thyroid medications?…… Y N
   - D. Antihistamines, decongestants? …… Y N
   - E. High blood pressure or heart medication? …… Y N
   - F. Steroids? …… Y N
   - G. Tranquilizers, Antidepressants ? … …… Y N

⇒ **Please continue on other side**

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H. Stomach or GI medications (antacids, etc.)? …… Y N
I. Cholesterol reducing drugs? …… Y N
J. Aspirin, ibuprofen, NSAIDS, anti-inflammatory drugs, narcotics, opioids, or other pain relievers? …… Y N
K. Weight reduction pills or diet aids (over the counter or "natural" products)? …… Y N
L. Any other regular medications, pills, supplements or drugs? …… Y N
M. Have you ever been advised not to take a medication? …… Y N

⇒ **PLEASE LIST ALL CURRENT MEDICATIONS HERE ⇒** _____

_____

_____

10. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:
    A. Local anesthetic (Novocaine-like drugs)? …… Y N
    B. Penicillin, Amoxicillin, Cephalosporins? …… Y N
    C. Other antibiotics? …… Y N
    D. Barbiturates, sedatives? …… Y N
    E. Aspirin, ibuprofen, NSAIDS, or other pain medicines? …… Y N
    F. Codeine or other narcotics or opioids? …… Y N
    G. Latex? …… Y N
    H. Metal of any kind (mercury, lead, aluminum, etc.)? …… Y N
    I. Chemicals or jewelry (rash or sensitivity)? …… Y N
    J. Food products? …… Y N
    K. Other allergies or reactions? …… Y N
    Please list _____

    _____
11. Do you have hay fever, frequent skin rashes, hives, etc.? …… Y N
12. Do you use alcohol? How much per day? _____ …… Y N
13. Do you smoke? …… Y N
    What product and how much per day? _____For how long?_____
14. Do you use chew tobacco? ……For how long? _____…… Y N
15. Are you, or have you been, in a drug or alcohol recovery program? …… Y N
16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? …… Y N
17. Do you wish to talk to the doctor privately about anything? …… Y N
18. Any additional comments? _____

    _____
19. **WOMEN**
    A. Are you taking birth control pills? …… Y N
    A. Are you pregnant, trying to become pregnant or any chance you might be pregnant? ……. Y N
    B. Are you Breast Feeding? …… Y N
    C. Are you taking hormonal replacement? …… Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____
Date Signature of person completing Health History

Doctor's Initials

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CONSENT FOR DENTAL TREATMENT

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing and signing.

You have the right to be informed about your diagnosis and planned procedure so that you can decide whether to have a procedure or not after knowing the risks, benefits and alternative options.
I understand that good oral hygiene is essential to prevent decay and to assist in the successful treatment of dental conditions. **INITIAL_____**

Drugs and Medications:
I understand that antibiotics, pain medications, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have told the doctor of any known allergies. I know it is important to take any medicines that are prescribed for me as directed to help minimize potential problems. Certain medications may cause drowsiness and I should not drive or operate hazardous equipment when using such drugs. If I have a problem, I should get appropriate medical care from either my doctor or in emergencies by calling 911. **INITIAL_____**

Fillings:
I understand that more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that my tooth may not be salvageable and I may need other treatment options including a root canal or extraction. I understand that major changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely “permanent” and usually require periodic replacement.
INITIAL_____

Crowns and Bridges:
I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor if that happens so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes in the color, shape, size, etc. of a crown I may want must be made prior to final fabrication of the restoration. It is my responsibility to return for tooth preparation and final cementation of the restoration as directed by my doctor. If the crown or bridge becomes dislodged at any time, I need to call the doctor. I understand I may need further treatment by a specialist if complications arise during treatment, and I am responsible for paying any of those costs. **INITIAL_____**

Dentures:
I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not “permanent.” Sore spots, altered speech and difficulty eating are common problems. Immediate

dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less desirable result. A natural process of resorption of the bone occurs making it necessary to have an annual checkup. If unsatisfactory stabilization of the dentures occurs, other options including dental implants may be needed to assist in stabilization. If it is necessary to remake the denture because I did not return in the time needed, there may be additional cost. **INITIAL_____**

Changes in Treatment Plan:
I understand that it may be necessary during treatment to change or add procedures because of conditions discovered during treatment that were not evident during examination. If so, I will be advised by my doctor. **INITIAL_____**

For Women
Some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills. **INITIAL_____**

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to have the recommended treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's Name Date

Patient's (or Guardian's) Signature Print Name Date

Doctor's Signature Date

Witness' Signature Date

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Thank you for choosing our office. We are dedicated to helping you have a positive feeling about your dental care. We know you will find our office as pleasant as it is professional each time you visit.

Insurance:
Your insurance policy is a contract between you and your insurance company, please remember that you are ultimately responsible for payment of fees to the office. Any balance remaining after 60 days is your responsibility and must be paid in full by you. We will bill your insurance for you as a courtesy but all co-pays and deductibles are due at the time of service. We will do our very best to answer all your questions about your insurance but please remember that while we consider ourselves very knowledgeable about dental insurance, we can't guarantee their coverage or benefits.

Initial: _____

Assignment of Benefit:
I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed above for any service provided to me by that organization.
I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for services to Blackwell Dentistry, my insurance carrier or other medical entity. A copy of this authorization will be kept on file by Blackwell Dentistry.

Initial: _____

Financial Policy:
Payment is due at the time services are rendered. We accept Visa, MasterCard, Discover Card, Debit, CareCredit, Cash and Check.

Initial: _____

HIPPA/Privacy Policy:
We take seriously the protection of your private information. A copy of our privacy policies is available at your request. **Please ask us if you would like a copy.**

_____ _____

Signature Date