TULSA DENTAL CENTER

General Dentistry for the Entire Family

Patient Information

Patients full name (Please Print) _____ Preferred _____

Circle: Male/ Female Age_____ Date of Birth _____SSN _____

Parent or Guardian_____ DOB _____

Mailing Address: _____

Apt #_____City _____ State _____ Zip _____

Home # _____ Cell # _____Business # _____

Emergency Contact: _____ Phone # _____

Relationship: _____

Email _____

Has any member in your family been a patient in this office before? YES / NO

If YES, please give name and relationship:

_____

How did you hear about us? Who referred you? (We would like to thank them)

_____

Dental History

Is this the patient's first dental visit? Yes___ No ___ Previous Dentist _____

Any injuries to your teeth or jaws? (Falls, blows, chips, etc.) Yes __No __

Please List _____

Do you have history of nail biting or thumb sucking? Yes __ No ___

If yes, please explain _____

Have you ever experienced any unfavorable reaction from previous dental care? Yes __ No __

Please Explain: _____

What is your main concern with your dental health? _____

Do you wish to save all teeth possible? Yes ___ No ___ How often do you brush? _____ Floss? _____

Would you like to change the color or look of your teeth? Yes __ No __

Explain _____

Medical Information

Patient's Physician _____

City _____ Phone #_____

Preferred Pharmacy _____

Location _____ Phone # _____

Check below if you **HAVE** a history of any of the following:

Heart murmur ___ require premed? ___ Brain Injury ___ Kidney/Liver involvement ___

Rheumatic Fever ___ Diabetic ___ Hep A ____ Hep B ___ Hep C ____ Aids ___ Epilepsy ___

Bleeding Problems ___ Seizures ___ Blood Disorder ___ Reaction to NSAIDS ___

Joint Replacement ___ High Blood Pressure ___ Low Blood Pressure ___

Any other heart conditions/medical conditions ___

Please list _____

None of the above ____

1. Are you presently under the care of a physician for any medical Problem(s)? Yes No
   If yes, please explain: _____
2. Are you currently taking any medications? Yes No
   List all medications:

   _____

   Have you ever been hospitalized or had surgery? Yes No
   If yes, please explain:

   _____
3. Are you allergic to any medication or metals or other? Yes No
   If yes, please list all allergies

   _____
4. Are you currently on or ever been on a pain management program? Yes
   No
5. Have you ever had history of substance abuse? Yes No
   If yes please explain

   _____
6. Do you smoke? Yes No If yes, How much daily? _____ Do you use tobacco? Yes No
7. **Women only**- Is there a possibility you could be pregnant?
   Yes___ No ___ Due date _____ OB Physician Name and contact info

   _____

Patient/Guardian signature _____

Date _____

Authorization and Financial Responsibility

Are you covered by a dental plan? Yes __ No __ Are you the policy holder? Yes __ No __

Name of policy holder: _____

What is your relationship to the policy holder? _____

Last Dental Visit _____

Have you received previous care under this plan? Yes __ No __

Policy Holder Information

Employer _____ Dental INS Carrier _____

SSN _____ Policy ID # _____

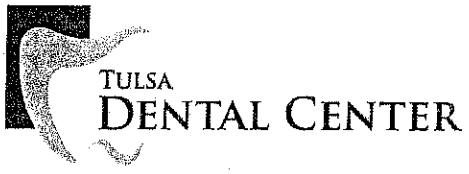
Date of Birth _____ Group # _____

INS Contact # _____

I hereby authorize the doctor or the associates to perform any and all treatment and consent to such methods, drugs and agents as may be indicated in connection with my dental care. I also authorize the Doctor or any agent working in her behalf, to use any radiograph or photograph for scientific publication or presentation. I understand that payment is expected on the day of service. I agree to pay all legal fees, court costs, and interest charges to the doctor pertaining to the collection of my delinquent account. This consent shall remain in effect until cancelled.

Signature of Patient/Guardian _____

Date _____



Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Tulsa Dental Center. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:
____ "Yes, I would like a copy of this form." (initialed by team member, copy provided by ___)

_____ _____
Printed Patient Name Date

_____
Patient Signature or Authorized Guardian

I refuse any photos, videos or other images, and/or testimonials to be used by Tulsa Dental Center for marketing purposes/Social Media and/or Advertising.

_____ _____
Authorized Signature Date

TULSA DENTAL CENTER
Joanna K Roulston, DDS
4824 South Union Avenue
Tulsa, Oklahoma 74107
918-446-6100

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Tulsa Dental Center's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Expiration -- 3 Years from Initial Signature; Insurance Change; Pt reaches age of 18 _____

I consent for the office of Dr Joanna Roulston to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ /_____ / _____

_____ /_____ / _____

_____ /_____ / _____

Signature: _____