WELCOME TO OUR PRACTICE

PLEASE FILL OUT ENTIRELY***

Name: Last		First		Middle	
Address: Street or P.O. Box #	City	State	Zip code	Phone Number Home: Work:	
Cell Phone:	Email:		May we contact you by e-mail? Yes □ No □		
Age: Yrs.	Birth Date: Mo. Day Year	Birthplace:		Married □ Single □ Divorced □	
Social Security No. (if child, parents)		Driver's License No:			
Occupation:	Employer:	How long employed?	EMP Address & Phone No.		
Person responsible for charges if not same as above: **SAME □ Skip if, same as above.**	Age:	Address:	Relationship:	Social Security No. Driver's License No.	
Occupation:	Employer:	How long Employed?			
Employer Address & Phone No.					

_____ _____

Insured Person's Full Name Date of Birth

_____ _____ _____

Social Security Number Relationship to Patient Work Phone

_____ _____ _____

Insurance Company Name **Member ID Number** Group or Local Numbers

_____ _____

Employer's Name Full Address of Employer

1. Why did you select our practice? _____
2. Whom may we thank for referring you? _____
3. Is another member of your family a patient of ours? _____
4. Emergency contact and phone number: _____
   _____
5. On a scale from -1 to +10 how would you rate your smile? _____
6. When was the last time you had complete radiographs? _____
7. Last Dentist _____
8. Have you ever had teeth removed? _____
   How long have these teeth been missing? _____
   Have these teeth been replaced? _____
   How? □ Bridge □ Partial □ Denture □ Implants

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. 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. 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. Master Card, 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 your treatment. Ask our team about Care Credit.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medications, 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 employees such assistance as 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

PLEASE KNOW THERE IS A $50 CHARGE FOR CANCELLING WITHOUT A 24 HOUR NOTICE

Dental Questionnaire and History

Please check yes or no to indicate if you have any of the following:

Bad Breath	Yes	No	Lip or cheek biting	Yes	No
Bleeding gums	Yes	No	Loose teeth or broken fillings	Yes	No
Blisters on lips or mouth	Yes	No	Mouth breathing	Yes	No
Burning sensation on tongue	Yes	No	Mouth pain when brushing	Yes	No
Chew on one side of mouth	Yes	No	Orthodontic treatment	Yes	No
Clicking or popping jaw	Yes	No	Pain around ear	Yes	No
Dry Mouth	Yes	No	Periodontal treatment	Yes	No
Fingernail biting	Yes	No	Sensitivity to cold	Yes	No
Food Collection between the teeth	Yes	No	Sensitivity to heat	Yes	No
Foreign objects	Yes	No	Sensitivity to sweets	Yes	No
Grinding teeth	Yes	No	Sensitivity when chewing	Yes	No
Gums swollen or tender	Yes	No	Sores or growths in mouth	Yes	No
Jaw pain or tiredness	Yes	No			

How often do you floss? _____ How often do you brush? _____

Briefly tell us how you feel about your teeth, your smile and dental expectations.

What are your expectations from this office? _____

Are you interested in keeping your natural teeth for the rest of your life? Yes No

If you are already missing some teeth, do you want them replaced? Yes No

Have you ever been told you have periodontal disease (gum disease)? Yes No

Do you like your smile? Yes No

If the answer is no, what changes would you like to see?

Rate your smile on a scale of 1-5 with 1 being the lowest score and 5 being the best possible: Lowest 1 2 3 4 5 Highest

Are you interested in whitening? Yes No

Do you ever feel nervous about dental treatment? (circle) Never Sometimes Always

Have you ever had nitrous oxide (laughing gas), general anesthesia or "twilight sleep" during a dental appointment? Yes No

Are you aware of anything that might prevent you from having either basic or cosmetic dental treatment? Yes No

Have your past dental office experiences been positive? Yes No

If no, please explain: _____

Is there anything in particular you would always like us to do for you? Yes No

Explain: _____

Is there anything in particular you would like us never to do? Yes No

Explain: _____

Do you have any dental concerns not listed here that you would like to bring to our attention? Yes No

Explain: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Tina J. Morehart D.D.S.
500 N. Walker, Suite E-500
Oklahoma City, OK. 73102

I understand that, the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this ***Notice of Privacy Practices Acknowledgement***, but was unable to do so as documented below.

Date:	Initials:	Reason:

CONSENT TO PERFORM DENTISTRY

1. I, hereby authorize and direct the dentist Dr. Tina J. Morehart and/or dental auxiliaries of her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, 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 (extractions) 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 anesthesia 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 anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indention 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 changing the treatment and cost. 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 judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, 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 there are rare potential risks such as unfavorable reaction of 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 purpose 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 instructions of the dentist. 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 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.

Patients Name: _____ Date: _____ Time: _____AM/PM

Name of Parent or Guardian: _____ Relationship to Patient: _____

Signature: Patient or Parent or Guardian: _____

Witness: _____ Date: _____

TINA J. MOREHART DDS
500 NORTH WALKER AVENUE / SUITE E-500 / OKC, OK 73102 / 405-208-8844

Financial Policy

Thank you for choosing Tina J. Morehart Dentistry. Our Primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options you may choose from:

Cash, Check, Credit Card, or Care Credit.
We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full with cash prior to completion of care for treatment plans of $1500 or more.

Care Credit is a no interest payment (for 6 months) plan that allows patients to make convenient monthly payments with flexible terms.

Credit Card payments: We accept most major credit cards.

Please note: Payment or payment arrangements are required prior to completion of treatment. If for any reason you discontinue treatment before completion, you will receive a refund less the cost of lab fees and treatment received.

For our patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.

There is a charge of $30 for returned checks. An interest fee of 1.5% will be assessed on accounts over 30 days past due.

_____ **A fee of $50 is charged for patients who NO SHOW or CANCEL without a 24 hour notice.**
Initial

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ _____
Patient, Parent or Guardian Signature Date

_____
Patient Name (Please Print)

_____ **If, we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.**
Initial