AQUA DENTAL
10507 East 91st Street, Suite 410
Tulsa, Oklahoma 74133
(918)455-7700
Fax (918)455-5441

Patient Information: Please completely answer the following information.

Name: _____ Date: _____
First Middle Last
Male _____ Female_____ Single_____ Married_____ Spouse Name _____
Patient's SSN: _____ Birthdate: _____ Employer: _____
Patient's Address: _____
Street
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone:_____ Cell Phone: _____
Email Address: _____

How did you hear about us?: _____
Were you referred by a Doctor?: Yes / No
If so, what Doctor and why?: _____

Person Responsible for Account: Patient_____ Mother/Father_____ Spouse_____
Name: _____ SSN: _____
Birthdate: _____ Employer: _____
Address: _____City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-mail address: _____

Insurance Information: Please completely answer the following information.

Primary Dental Insurance:
Patient Spouse Other
Name: _____
First MI Last
SSN: _____ DOB: _____
Employer: _____
Insurance Co: _____
Group # _____ ID # _____

Secondary Dental Insurance:
Patient Spouse Other
Name: _____
First MI Last
SSN: _____ DOB: _____
Employer: _____
Insurance Co: _____
Group # _____ ID # _____

Initial the following:
I authorize:
_____ Administration of medications, images, x-rays and treatment for my dental care.
_____ Insurance payments made directly to Aqua Dental (I am responsible for the remaining balance).
_____ I understand that I am responsible for collection charges (30%-50% of the outstanding balance) involved for non-payment on my account.
_____I give permission for Aqua Dental to take and use photographs of myself for website, publicity or general office use. Aqua Dental will not sell or distribute any photographs for third party use.

Signature: _____ **Date**: _____

Medical History

Primary Medical Doctor: _____ Phone: _____

Preferred Pharmacy : _____ Pharmacy Location: _____

Do you have or have you ever had any of the following conditions: (Please Circle All That Apply)

Blood thinners
Abnormal Bleeding/Prolonged bleeding
Anemia / Blood Disorders
Hemophilia
Asthma
Arthritis / Rheumatism
Artificial Joints: _____
Chest Pain
Heart Attack- Date _____
Heart Surgery- Type _____ Date _____
Heart Stent(s) - Date _____
Heart Transplant - Date: _____
Heart Problems (Murmur, Valve Prolapse, other _____)
Artificial Heart Valve
Congenital Heart Defect
Pacemaker
Rheumatic fever or Rheumatic Heart Disease
High Blood Pressure/ Low Blood Pressure
Ulcers
Emphysema/COPD
Osteoporosis or Osteopenia
Osteoporosis Medication/Bisphosphonates
Diabetes (Insulin _____Units/day)
Diabetes (controlled by oral meds)
Fasting Blood sugars _____ Hgb 1 AC_____
Cancer type: _____
Chemotherapy - Date(s) _____
Radiation – Date(s) _____
Hepatitis
Liver Disease
Kidney Problems/ Kidney Transplant
Tuberculosis
Seizures/ Epilepsy
Thyroid Problems
HIV / AIDS
Stroke or TIA - Date: _____
Drug Abuse and/or Alcohol Abuse
Psychiatric Problems – Type _____
Problems with Anesthetic or Anesthesia
Unexplained numbness in mouth; lump in mouth, throat or neck
Sores on lips, mouth or cheeks that do not heal in 2-3 weeks

Allergies to medication _____

Any other conditions not mentioned above _____

Do you smoke? Yes / No **Smokeless tobacco?** Yes / No **Electric cigarettes?** Yes / No
Daily tobacco use? _____ **How many years?** _____

When was your last dental cleaning? _____
How often do you Brush your teeth? _____ **Floss?** _____

I certify that the above statements regarding my medical and dental conditions are complete and accurate. I will not hold Dr. Owens, or any member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature:_____ **Date:_____**

Dr. Signature:_____ **Date:_____**

Prescription Medication	**Dosage**	**How often do you take this?**	**Why are you taking this?**
Example: *Hydrochlorothiazide*	*50mg*	*Once Daily*	*High Blood Pressure*
Over-the-counter meds & nutritional supplements	**Dosage**	**How often do you take it?**	**Why are you taking it?**
Example: *Calcium Supplement*	*1 tablet*	*Once Daily*	*Strengthen Bones*

AQUA DENTAL
Dr Jim Owens / Dr Sam Owens / Dr Gary Fisher/Dr Beau Evans
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the use or disclosure of the protected health information ("PHI") as described below. By authorizing the use or disclosure of the PHI described below, I authorize the custodian of the PHI (1) to open the PHI for review or inspection by the person(s) indentified below, and (2) to furnish the person(s) identified below with a copy of the PHI if he or she so requests.

Patient Name: _____ Date: _____

Description of PHI requested: i.e. appointment reminder, inform of referral appointments, test results, prescription information, entire contents of dental records, including diagnosis, treatment details and financial information. I give my consent for the office of Aqua Dental to contact me and leave messages on a recording device or to share my personal information with the following persons listed below.

I authorize Aqua Dental to release and/or disclose the PHI described above to:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

_____ I do not want my information released to anyone.

I may refuse to sign this acknowledgement.

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

This Authorization will expire on the following date: _____
****(If no expiration date is listed, this form will expire 3 years from date signed.)

Signature: _____ Date:_____

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I want to take this opportunity to welcome you to Aqua Dental office. Thank you for choosing and entrusting us as your dental healthcare provider.

Financial Policy

Payment is due at the time services are rendered, which includes self-pay, insurance copays and/or deductibles. A current insurance card must be presented before services are rendered. As a service to our patients, a representative from our office will contact your insurance company to verify benefits and eligibility. Our office will strive to maximize your benefits. However, the remainder of the balance after the estimated insurance portion will be the responsibility of the patient on the date of service.

Accounts with balances are considered past due at 31 days without a payment. Once an account is delinquent 90 days past due, it will be considered for collection procedures and placed with an independent agency. Should your account be turned to an independent agency for collection procedures, all future services will be on cash only basis.

We realize information surrounding dental health care can be difficult and confusing at times, which is why we are here to assist in this process. If you have any questions or should feel that you cannot meet the terms set forth with this financial policy, please feel free to contact our office at (918) 455-7700.

Again, thank you for choosing Aqua Dental. We look forward to serving you.

Sincerely,
Deborah Davis
Financial Coordinator

“I have read, understand and agree to the provision of this financial policy.”

_____ _____
Patient’s Name Date

_____
Patient/Legal Guardian’s Signature