

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (Initial)

Gender (M/F): \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment

City State Zip Code

Phone #'s: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Fax: \_\_\_\_\_ Pager: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code Phone

**Spouse or Responsible Party Information**

Name: \_\_\_\_\_  
(Last) (First) (Initial)

Gender (M/F): \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment

City State Zip Code

Phone #'s: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Fax: \_\_\_\_\_ Pager: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code Phone

**Other Information**

Name of nearest relative NOT living with you: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Phone Numbers: Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

**Referral Information**

Whom may we thank for referring you to our practice?  Another Patient, friend  Another patient, relative

Dental Office  Yellow Pages (PLEASE SPECIFY) \_\_\_\_\_  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Health History

Patient Name: \_\_\_\_\_ Date of Last Dental Visit \_\_\_\_\_

Who was your last dentist: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

If female, are you pregnant now? YES NO If yes, due date: \_\_\_\_\_

**Check any symptom(s) or conditions below that you currently have or had in the past year:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Codeine Allergy       | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Rheumatism         |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Sinus Problems     |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Dizziness/Fainting    | <input type="checkbox"/> Stomach Problems   |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Aspirin             | <input type="checkbox"/> Latex                 | <input type="checkbox"/> Sulfa Drug Allergy |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bleeding Gums       | <input type="checkbox"/> Penicillin Allergy    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Poor Circulation      | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bruise Easily       | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Rapid Heartbeat       | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Respiratory Problems  |   |

Have you ever had any complications following dental treatment? YES NO  
If yes, please explain: \_\_\_\_\_

Have you ever been admitted to a hospital or needed emergency care during the past two years? YES NO  
If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician? YES NO  
If yes, please explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

### Insurance Information

Individual responsible for this account: \_\_\_\_\_  
(Last) (First) (Initial)

Relationship to Patient \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Responsible Party Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Insurance Company \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_  
Signature of responsible party

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_ **Date:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
**Signature of patient, parent or guardian**

\_\_\_\_\_ **Date:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
**Signature of patient, guarantor of payment/responsible party**

**Wrany Southard, D.D.S.  
6333 South Memorial Drive, Suite G  
Tulsa, Oklahoma 74133  
(918) 294-1144**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

*I may refuse to sign this acknowledgement.*  
**I have received a copy of Dr. Wrany Southard's Notice of Privacy Practices.**

\_\_\_\_\_  
**Please Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Office Use Only**

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

- Individual Refused to Sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: \_\_\_\_\_