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:

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

Are you currently taking any medications? Purpose? Please list_____

Have you ever had any complications following dental treatment? 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:_____

Do you have any additional health problems that need further clarification? YES NO
If yes, please explain _____

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.

_____ Date:_____
Signature of patient, parent or guardian

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 and Financial Information

Consent:

I hereby grant authority to Dr. Southard and/or his staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Southard to make a thorough diagnosis of my/my charge's dental needs. Upon such diagnosis, I authorize Dr. Southard to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to anesthetics, sedatives, nitrous oxide sedation and other medication as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identity information will be kept private.

Financial Information:

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

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 ninety days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Southard, I agree to pay therefore the reasonable value of said services to Dr. Southard, 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.

Insurance:

Southard Dental provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations during any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Southard Dental staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Southard Dental. However, if you are paid by the insurance company instead of Southard Dental, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

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:**_____