PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

What is your reason for today's visit? _____
How long has this been bothering you? _____

Who referred you to us? _____
Name of physician: _____ Phone Number: _____

Medical History

Have you been examined by a physician within the last five years? If so, when? _____ Yes No
Are you presently being treated by a physician for any condition? Yes No
If so, for what condition(s)? _____
Are you taking any prescription or non-prescription medications at this time, or have you within the Yes No
Last 6 weeks? If so, what are they? _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you take an aspirin daily? If so, why? _____ Yes No

Are you ALLERGIC to any of the following medications or materials?

Penicillin	Yes	No	Sulfa Drugs	Yes	No	Erythromycin	Yes	No	Tetracycline	Yes	No	
Aspirin	Yes	No	Codeine	Yes	No	Dental Anesthetic	Yes	No	Other Medicine	Yes	No	_____
Acrylic	Yes	No	Latex	Yes	No	Metals	Yes	No	Other Materials	Yes	No	_____

Have you ever had, and/or been treated for, any of the following conditions?

Heart Attack	Yes	No	Bleed/Bruise Easily	Yes	No	Kidney Disease	Yes	No	Seizures	Yes	No
Heart Murmur	Yes	No	Breathing Problems	Yes	No	Liver disease	Yes	No	Dizziness/Fainting	Yes	No
Mitral Valve Prolapse	Yes	No	Lung Disease	Yes	No	Jaundice	Yes	No	Nervousness	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Hepatitis	Yes	No	Psychiatric Care	Yes	No
Artificial Heart Valve	Yes	No	Seasonal Allergies	Yes	No	Arthritis	Yes	No	Chemotherapy	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Artificial Joints	Yes	No	Radiation Therapy	Yes	No
Heart Disease	Yes	No	Thyroid Disease	Yes	No	Ulcers	Yes	No	Blood Transfusion	Yes	No
Swelling of Limbs	Yes	No	Excessive Thirst	Yes	No	Eating Disorders	Yes	No	Drug Addiction	Yes	No
High Blood Pressure	Yes	No	Hypoglycemia	Yes	No	GI Disorders	Yes	No	HIV / AIDS	Yes	No
Low Blood Pressure	Yes	No	Diabetes	Yes	No	Stroke	Yes	No	Syphilis / Herpes	Yes	No

Have you ever been treated for a tumor, cyst, or any type of cancer? If so, what type and when? _____ Yes No
_____
Have you ever been seriously ill or hospitalized? If so, what was the condition, and when? _____ Yes No
_____
Please list any other diseases or conditions that you have been treated for: _____
_____
Do you have a family history of any of the conditions listed or mentioned above? If so, which ones? _____ Yes No
_____

Please answer the following questions:

Are you on a special diet, or diet medication? If so, which type and for how long? _____ Yes No
_____
Do you smoke? If so, how much do you smoke per day? _____ Yes No
Do you use any form of smokeless tobacco? If so, what, and how much do you use it? _____ Yes No
_____
Do you use alcoholic beverages? If so, how often? _____ Yes No

Women (please check if applicable): ____Pregnant or trying to become pregnant ____Nursing ____Using Birth Control Pills

I certify that to the best of my knowledge, the above information is complete and correct.

Patient Signature (Parent or Guardian) _____ **Date:** _____

History Reviewed by (Doctor) _____ **Date:** _____

PATIENT DENTAL QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

Dental History

How long has it been since your last dental examination? _____ Since your last dental cleaning? _____

Are you apprehensive about receiving dental treatment? Yes No

For Children (please check all that apply): ____First dental visit ____Relaxed ____Nervous____Bad previous experience

Are you unhappy with your smile? Yes No
Is there anything you would like to change about your smile? If so, what would that be? Yes No
_____

Do you have a specific dental concern? If so, what is it? _____ Yes No
Do you have any broken teeth? Yes No
Are you missing any teeth? Yes No
Do you have any teeth that are sensitive to biting and chewing? Yes No
Do you think that you might have any tooth decay? Yes No

Do you have any areas that trap food between the teeth? Yes No
Do have any loose teeth? Yes No
Do you have any bleeding, swelling, or soreness in your gums? Yes No
Have you ever been diagnosed with periodontal disease? If so, how long ago? _____ Yes No

Do you clench or grind your teeth? Yes No
Do you have any problems with your jaw joints, such as pain, popping/clicking, or limited opening? Yes No
Does your jaw ever get stuck in the open position? Yes No
Does chewing or yawning ever cause pain? Yes No
Do you ever have pain in or near your ears or cheeks? Yes No
Have you ever been treated for TMJ problems? Yes No

Do you currently wear dentures or partial dentures? If so, how old are they? _____ Yes No
If so, please mark which you have? ____Upper Denture ____Lower Denture ____Upper Partial ____Lower Partial
If you wear dentures or partial dentures, is there anything that you would like change about them? Yes No
If so, what is it? _____
If you wear dentures or partials, or have any missing teeth, would you like to learn more about implants? Yes No

Do you use a mouthwash regularly? If so, which one? _____ Yes No
Which toothpaste do you use the most? _____
How often do you brush your teeth? _____
How often do you floss? _____
Do you use a fluoride supplement or rinse on a regular basis? If so, which one? _____ Yes No

I certify that to the best of my knowledge, the above information is complete and correct.

Patient Signature (Parent or Guardian) _____ **Date:** _____

History Reviewed by (Doctor) _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the practices that are described in this Notice while it is in effect. This Notice takes effect (02/14/03), and will remain in effect until we replace it.

We reserved the right to change our privacy practices and the term of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health and personal information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your person representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health and person information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail and work messages, postcard, e-mail or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, the fee is $50, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health or person information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003, if you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative location (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or your disagree with a decision we made about access to your health or personal information or in response to a request you made to amend or restrict the use or disclosure of your health or personal information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: 405-844-6333 Fax: 405-844-6331

Website: www.coffeecreekfamilydentistry.com

Email: smile@ruddfamilydentistry.com

Address: 775 West Covell Road, Suite160 Edmond, Oklahoma 73003

_____

I have read and understand what my HIPPA Privacy rights are.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____
(if applicable)

GETTING TO KNOW YOU

Patient Information

Last _____ First_____ MI_____

Preferred Name: _____ Gender: Male/Female Birthday: M____ D____ Y____

Social Security # _____ DL# _____ State _____

Home Phone # ( ) _____-_____ Cell # ( )_____-_____ Email_____

Street Address _____ City _____ ST____ Zip Code _____

Mailing Address (if different than above) _____

Occupation: _____ Employer: _____

Employer Address: _____

Work Phone # ( ) _____-_____

Nearest Relative (not living with you) _____ Relationship: _____

Street Address _____ City _____ ST____ Zip Code _____

Contact Phone # ( ) _____-_____

Whom May We Thank For Referring You To Our Office? _____

Spouse, Parent or Guardian Information

Last _____ First_____ MI_____

Street Address _____ City _____ ST____ Zip Code _____

Contact # ( ) _____-_____

(We require all persons under the age of 18 years old be accompanied by guardian or parent)

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

COFFEE CREEK FAMILY DENTISTRY
FINANCIAL RESPONSIBILITY FORM

Thank you for choosing us as your dental care provider. We take pride in our commitment to providing you with our best effort in diagnosing and treating your dental care needs in a safe and comfortable environment. The following information is intended to promote an understanding of our financial policies. Please read and sign this policy prior to the start of any treatment.

FOR PATIENTS WITHOUT DENTAL INSURANCE

We require all procedures to be paid for at the time of service. Arrangements for payment of major reconstructive or cosmetic procedures approved by Dr. Rudd may be made for you by our financial coordinator. Our financial coordinator will inform you of the available payment schedule, they will also be happy to assist you with information for outside financing plans we offer.

FOR PATIENTS WITH DENTAL INSURANCE

If you have dental insurance, we will file the claims for you, as a courtesy. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to inform our office as soon as possible to update those changes for your record. **While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to us. We do accept payments from the dental insurance companies; however, it is a contract between you, your employer and the insurance company. We can provide you with a verbal ESTIMATE of your out of pocket expense for any treatment planned by the doctor. Please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. We are also happy to send a Predetermination of Benefits to your insurance prior to any procedure. Please note that any difference in payment from your insurance company and your account balance is your responsibility.** If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder. Payment for co-pays and/or deductibles is due at the time services are provided. Any balance older than 60 days will be subject to interest charges per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney and additional collection fees will be applied to any unpaid balance. Any check returned unpaid will incur a $15 NSF check fee. We request a 48 hour cancellation notice for scheduled appointments. A cancellation fee of $50 may be charged if a 48 hour notice is not given.

I have read the above financial policy and agree to comply with all terms and conditions and understand that I am responsible for all costs of procedures performed for me or those for which I am responsible at Coffee Creek Family Dentistry.

_____ _____

Patient/Responsible Party Signature Date

Thank you for trusting us with your care.

Dental Insurance Information

We are happy to process your insurance claims complimentary to maximize you benefits. Since insurance can be confusing, we ask that you call or contact us with specific questions. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 45 days, you are responsible for the entire balance, paid in full. If you have any questions, our courteous staff is always available to answer them.

Primary Insurance Information:

Dental Insurance Company_____ Phone #_____

Name of the Subscriber: _____Member I.D. #_____

Group #_____SS# of the Subscriber: _____ Birthday: _____

Employer of Subscriber: _____ Contact # of Subscriber (_____) _____-_____

Patients Relationship to Subscriber: Self / Spouse / Child / Other _____

Secondary Insurance Information:

Dental Insurance Company_____ Phone #_____

Name of the Subscriber: _____Member I.D. #_____

Group #_____SS# of the Subscriber: _____ Birthday: _____

Employer of Subscriber: _____ Contact # of Subscriber (_____) _____-_____

Patients Relationship to Subscriber: Self / Spouse / Child / Other _____

We will only file primary and secondary insurance. If you have a third insurance or a cafeteria Plan or HAS, you will need to be responsible for filing with those agencies. We will be happy to provide you with copies of any information you may need to file these documents for reimbursement.

Signature: _____ Date: _____