ATLANTA PLACE
DENTISTRY

Dentistry + Anesthesiology = Safe/Comfort
2106 S. Atlanta Pl. ~ Tulsa, Ok ~ 74114 ~ 918~743~7444
www.YourTulsaDentist.com

Patient Information

Name:______________________________Marital Status:________Today's Date:_____________________

Address:____
Street City State Zip

Date of Birth_______/_________/________Telephone: (______)____________(_____)________________
Month Day Year Home Mobile

S.S. #_____-________-________________ Work Phone Number: (______)____________________________

Place of Employment_____________________________ e-mail address___________________________________

Person Responsible for Account: ____________________Method of Payment: Cash____Check_____Credit Card_________________________

Insurance Information: (*PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST, Thank You.)*

DENTAL Insurance Company:_______________________Subscriber Name (person insured)__________________________

ID Number on Card or Subscriber's SS # __________________Subscriber's D.O.B. _______________________________

IF PATIENT IS A MINOR (under the age of 18) PLEASE COMPLETE THE FOLLOWING:

Responsible Party: (Parent or Guardian)____

Phone Number: Home__________________Mobile________________Work___________

Address (if different than above):____

Authorization:

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature:_____________________________Today's Date __________________DATE OF BIRTH_____________________________

SERVICE CHARGE:

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

SIGNATURE___________________________________Date:_____________________________________

DENTAL HISTORY

Referred by__________________ How would you rate the condition of your mouth? ▢ Excellent ▢ Good ▢ Fair ▢ Poor
Previous Dentist ______________________________ How long have you been a patient?________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: ▢ 3 mo. ▢ 4 mo. ▢ 6 mo. ▢ 12 mo. ▢ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) __________ ▢ ▢
2. Have you had an unfavorable dental experience? __________ ▢ ▢
3. Have you ever had complications from past dental treatment? __________ ▢ ▢
4. Have you ever had trouble getting numb or reactions to local anesthetic? __________ ▢ ▢
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? __________ ▢ ▢
6. Have you had any teeth removed? __________ ▢ ▢

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? __________ ▢ ▢
8. Have you ever whitened (bleached) your teeth? __________ ▢ ▢
9. Are you self conscious about your teeth? __________ ▢ ▢
10. Have you been disappointed with the appearance of previous dental work? __________ ▢ ▢

BITE AND JAW JOINT

11. Do you / would you have any problems chewing gum? __________ ▢ ▢
12. Do you / would you have any problems chewing bagels or other hard foods? __________ ▢ ▢
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? __________ ▢ ▢
14. Are your teeth crowding or developing spaces? __________ ▢ ▢
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? __________ ▢ ▢
16. Do you have any problems with sleep or wake up with an awareness of your teeth? __________ ▢ ▢
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) __________ ▢ ▢
18. Do you have tension headaches or sore teeth? __________ ▢ ▢
19. Do you wear or have you ever worn a bite appliance? __________ ▢ ▢

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? __________ ▢ ▢
21. Do you have a dry mouth? __________ ▢ ▢
22. Are any teeth sensitive to hot, cold, biting or sweets? __________ ▢ ▢
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? __________ ▢ ▢
24. Do you avoid brushing any part of your mouth? __________ ▢ ▢
25. Do you feel or notice any holes (i.e. pitting) in your teeth? __________ ▢ ▢

GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? __________ ▢ ▢
27. Have you ever experienced gum recession? __________ ▢ ▢
28. Is there anyone with a history of periodontal disease in your family? __________ ▢ ▢
29. Do your gums bleed when brushing, flossing or eating? __________ ▢ ▢
30. Are your teeth becoming loose? __________ ▢ ▢
31. Have you ever noticed an unpleasant taste or odor in your mouth? __________ ▢ ▢
32. Have you experienced a burning sensation in your mouth? __________ ▢ ▢

Patient's Signature ______________________________ Date __________

Doctor's Signature ______________________________ Date __________

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________ Purpose ______________

What is your estimate of your general health? ▢ Excellent ▢ Good ▢ Fair ▢ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury ______	▢	▢
2. an allergic reaction to		
▢ aspirin, ibuprofen, acetaminophen		
▢ penicillin		
▢ erythromycin		
▢ tetracycline		
▢ codeine		
▢ local anesthetic		
▢ fluoride		
▢ metals (gold, stainless steel)		
▢ latex		
▢ any other medications ______		
3. heart problems ______	▢	▢
4. heart murmur ______	▢	▢
5. rheumatic fever ______	▢	▢
6. scarlet fever ______	▢	▢
7. high blood pressure ______	▢	▢
8. low blood pressure ______	▢	▢
9. a stroke ______	▢	▢
10. artificial prosthesis (i.e. heart valve or joints) ______	▢	▢
11. anemia or other blood disorder ______	▢	▢
12. prolonged bleeding due to a slight cut ______	▢	▢
13. emphysema ______	▢	▢
14. tuberculosis ______	▢	▢
15. asthma ______	▢	▢
16. breathing or sleep problems (i.e. snoring, sinus) ______	▢	▢
17. kidney disease ______	▢	▢
18. liver disease ______	▢	▢
19. jaundice ______	▢	▢
20. thyroid or parathyroid disease ______	▢	▢
21. hormone deficiency ______	▢	▢
22. high cholesterol ______	▢	▢
23. diabetes ______	▢	▢
24. stomach or duodenal ulcer ______	▢	▢
25. digestive disorders (i.e. gastric reflux) ______	▢	▢

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ______	▢	▢
27. arthritis ______	▢	▢
28. glaucoma ______	▢	▢
29. contact lenses ______	▢	▢
30. head or neck injuries ______	▢	▢
31. epilepsy, convulsions (seizures) ______	▢	▢
32. neurologic problems ______	▢	▢
33. viral infections and cold sores ______	▢	▢
34. any lumps or swelling in the mouth ______	▢	▢
35. hives, skin rash, hay fever ______	▢	▢
36. venereal disease ______	▢	▢
37. hepatitis (type ___) ______	▢	▢
38. HIV / AIDS ______	▢	▢
39. tumor, abnormal growth ______	▢	▢
40. radiation therapy ______	▢	▢
41. chemotherapy ______	▢	▢
42. emotional problems ______	▢	▢
43. psychiatric treatment ______	▢	▢
44. antidepressant medication ______	▢	▢
45. alcohol / drug dependency ______	▢	▢

ARE YOU:	YES	NO
46. presently being treated for any other illness ______	▢	▢
47. aware of a change in your general health ______	▢	▢
48. taking medication for weight management (i.e. fen-phen)	▢	▢
49. taking dietary supplements ______	▢	▢
50. often exhausted or fatigued ______	▢	▢
51. subject to frequent headaches ______	▢	▢
52. a smoker or smoked previously ______	▢	▢
53. considered a touchy person ______	▢	▢
54. often unhappy or depressed ______	▢	▢
55. FEMALE - taking birth control pills ______	▢	▢
56. FEMALE - pregnant ______	▢	▢
57. MALE - prostate disorders ______	▢	▢

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(You may refuse to sign this acknowledgement.)

I have received a copy of Atlanta Place Dentistry's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

CONTACT RELEASE INFORMATION

I agree to permit Priscila Jelsing, DDS and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

____
Signature

****
____

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:
____

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INFORMED CONSENT AND AUTHORIZATION

I certify that I have read and understand all nine pages of the Informed Consent which outlines the general treatment consideration as well as the potential problems and complications of restorative/prosthodontic treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document. I understand that during and following the contemplated procedure, conditions may be become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment.

SIGNED:_______________________________DATE:_____________

PRINTED NAME:____

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FINANCIAL and APPOINTMENT POLICY

We feel that everyone benefits when there is a clear understanding of our financial policy prior to treatment.

1. Payment is due at the time of services. An estimate of your total fee will be outlined in detail with you at the time of your initial visit.

2. On treatment involving laboratory fees (crowns, bridges, dentures), you may choose to pay in halves. Our Financial Coordinator will assist you in setting this up.

3. **Patients with insurance:** As a courtesy, our office will file your insurance if you provide us with the proper information. You are expected to pay your deductible and any out-of-pocket portions at the time services are rendered. We will accept benefits for the remaining balance. In the event your insurance overpay, we will refund you promptly. If your insurance company does not make payment within 45 days, you are immediately responsible for the remaining balance.

4.**Finance charge:** If an account, which is the patient's responsibility, is not paid in full within 30 days a 1.5% finance charge will be added to the account balance per month.

5. **Missed Appointment Fee**: We reserve an exclusive block of time for your appointment with us and we ask for your consideration in **giving us at least *24* hours notice for a hygiene appointment and at least *48* hours for dental appointment that you might need to reschedule.**

6.Returned checks: there is a fee of $25.00 for any check returned by the bank.

7. For your convenience:, we accept Visa, MasterCard, American Express, and Discover cards. We can also assist you in obtaining financing through Care Credit, Wells Fargo, or Capital One Healthcare.

I have read and agree to the above Financial Policy.

____

Name and Date