magnolia
FAMILY DENTISTRY

Leaha Nels DDS
101 North Douglas Boulevard, Suite T,
Midwest City, OK 73130

Welcome to our office! To assist us in serving you, please complete the following confidential form.

GENERAL INFORMATION

Patient's name ______________________________ Preferred name __________________ Date of birth _____________

If minor, legal guardian's name ____________________ Cell phone________________ Other phone ________________

Address ____ City ___________________ State ________ Zip ___________

Social Security number: _________________________ E-mail address _______________________________________

Preferred contact methods:

For appointment confirmations: ☐Cell phone call ☐Cell phone text ☐Other phone call ☐E-mail

For treatment communications: ☐Cell phone call ☐Cell phone text ☐Other phone call ☐E-mail

If texting is preferred please list wireless carrier: ___________________

How did you hear about our office? ☐Mailer ☐Search engine ☐Other_________________________________

☐Driving by ☐Facebook ☐Current patient, please give their name so we may thank them. _______________________

☐Live in area

INSURANCE INFORMATION

Dental Insurance Company __________________________ Group number/member ID __________________________

Are you the policy holder? ☐yes ☐no If no, who? ____

Policy holder date of birth_________________ Policy Holder Social Security Number _____________________________

Do you have a secondary insurance? ☐yes ☐no Policy Holder name ____________________________________

Dental Insurance Company __________________________ Group number/member ID __________________________

Policy holder date of birth_________________ Policy Holder Social Security Number _____________________________

NOTICE OF PRIVACY PRACTICES

Acknowledgement of receipt of notice of privacy practices, you may refuse to sign this acknowledgement.

I, ______________________________________, have received a copy of this office Notice of Privacy Practices.
name of patient, or legal guardian if under 18 years

____ _______________________
printed name of patient Date

____ _______________________
signature of patient, or legal guardian if under 18 years Date

OFFICE AND PAYMENT POLICIES

The following is an outline of our office and payment policy, please read it carefully.

- Please notify our office when you have a change of address, phone number or insurance information.

APPOINTMENTS

- When time permits, as a courtesy, we will call to confirm your appointment. However, it is the responsibility of the patient to keep or cancel the appointment whether or not we were able to make contact for confirmation.
- We request 24 hour notice when cancelling an appointment. Less than 24 hour notice when cancelling will be considered a broken appointment.
- We will be unable to reschedule an appointment if you have three (3) or more broken appointments.

INSURANCE

- We will gladly file your insurance as a courtesy and accept assignment of benefits. However, if the insurance company does not pay after 60 days post treatment, it will be your responsibility to pay Magnolia Family Dentistry for the services and resubmit the insurance on your own.
- You are responsible for payment of any service applied to your deductible.
- You are responsible for payment of any amount over your annual maximum allowance, which includes dental services performed in the office, as well as any other offices.

PAYMENT

- Total payment is due for services when treatment is rendered. We accept Visa, MasterCard, Discover, cash and check.
- There will be a $25 fee for all returned checks.
- Should your account be sent to collections you will be responsible for legal fees and associated costs.

Please inquire with our staff if you are uncertain about any subject outlined above. Your signature will certify that you understand and will comply with this policy.

I have read and fully understand the above policy.

____ ___________________________

signature of patient, or legal guardian if under 18 years date

GENERAL CONSENT

I, the undersigned, authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all types of dental treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as they deem appropriate.

____ ___________________________

signature of patient, or legal guardian if under 18 years date

MEDICAL HISTORY

Are you currently under a physician's care? ☐yes ☐no
Name of physician ______________________________
Do you have any artificial joints? ☐yes ☐no
Do you have an artificial heart valve? ☐yes ☐no
Were you born with a heart defect? ☐yes ☐no
Have you had endocarditis? ☐yes ☐no
Have you ever taken bisphosphonates
(ex: Fosamax, Boniva)? ☐yes ☐no
Females: Are you or could you be pregnant? ☐yes ☐no

Have you had OR do you currently have any of the following?

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Asthma
☐ Alzheimer's disease
☐ Anemia
☐ Blood disease
☐ Cancer
☐ Chemotherapy
☐ Chest pain
☐ Diabetes
☐ Dementia
☐ Depression
☐ Drug dependency
☐ Excess Bleeding
☐ Fibromyalgia
☐ Frequent headaches
☐ Heart attack
☐ Herpes
☐ High or low blood pressure
☐ Hepatitis
☐ Lupus
☐ Kidney disease
☐ Pacemaker
☐ Radiation therapy
☐ Osteoporosis
☐ Seasonal allergies
☐ Seizures
☐ Sinus problems
☐ Stroke
☐ Tuberculosis

Please list any other medical condition not listed above you have had OR currently have: ______________________________

____

Are you allergic to or have you reacted adversely to any of the following?

☐ Latex materials
☐ Penicillin
☐ Local anesthetics
☐ Codeine
☐ Sulfa drugs
☐ Barbiturates or sedatives
☐ Aspirin
☐ Other ______________
____

Please list current medications: ______________________________

____

____

DENTAL HISTORY

Date of last dental visit ______________________
Are you here for a second opinion? ☐yes ☐no
Are you experiencing dental pain? ☐yes ☐no
If so, where? ______________________
Do your gums bleed? ☐yes ☐no
Do you prefer to receive nitrous (laughing gas) during dental treatment? ☐yes ☐no

Do you experience jaw pain? ☐yes ☐no
Do you grind or clench your teeth? ☐yes ☐no
Do you wear a nightguard? ☐yes ☐no
Do you experience dry mouth? ☐yes ☐no
Do you use tobacco? ☐yes ☐no
How often do you brush? ______________________
How often do you floss? ______________________

Are you happy with the appearance and health of your smile? ☐yes ☐no
If no, what are you unhappy with?

☐ bad breath
☐ color of teeth
☐ size/shape of teeth
☐ broken teeth
☐ chipped teeth
☐ worn teeth
☐ missing teeth
☐ sensitive teeth
☐ stained teeth
☐ crooked teeth
☐ crowded teeth
☐ too much space between teeth
☐ bleeding gums
☐ too much gum showing
☐ current dentures
☐ previous dental work
other ____________________
____

I certify, to the best of my knowledge, the information given above is accurate.

______________________________ signature of patient , or parent if under 18 years

______________________________ date