WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date:______________________ E-mail Address:______________________

Name: ____ ☐ Male ☐ Female
LAST FIRST MI Mr Mrs Ms Dr

Birthdate:__/__/__ Age:________ Soc. Sec. #:____________________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: ____
Street City State Zip

Home Phone: (___)____________ Cell/other: (___)____________ Work Phone: (___)____________ Ext: Driver's Lic.#:____________

Where & when are the best times to reach you?____________________ Whom may we thank for referring you? ____________________

Other family members seen by us: ____

Employer:____________________ How long there? ________ Occupation: ____________________

Employer's Address: ____
Street / PO Box City State Zip

Emergency Contact

His / Her Name:____________________ Relation: ____________ Home Phone: (___)____________ Work Phone: (___) ____________

Address: ____
Street City State Zip

Spouse Information

His /Her Name: ____________________ Birth date: __/__/__ Social Security #: ____________________

Employer: ____________________ Work Phone: (___)____________ Ext. Driver's License #:____________________

Insurance Information

Primary Insurance Dental Coverage ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name:____________________ Phone:(___) ____________ Group # (Plan, Local or Policy #): ____________

Insurance Co. Address: ____
Street / PO Box City State Zip

Insured's Name: ____________________ Insured's Social Security #: ____________ Insured's Birth date: __/__/__ Relation: ____________

Insured's Employer:____________________ Employer's Address:____________________
Street / PO Box City State Zip

Secondary Insurance Dental Coverage ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name:____________________ Phone:(___) ____________ Group # (Plan, Local or Policy #): ____________

Insurance Co. Address: ____
Street / PO Box City State Zip

Insured's Name: ____________________ Insured's Social Security #: ____________ Insured's Birth date: __/__/__ Relation: ____________

Insured's Employer:____________________ Employer's Address:____________________
Street / PO Box City State Zip

Dental History

Why have you come to the dentist today?______________________________

____

Are you currently in pain? ☐ Yes ☐ No

Do you have antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Have ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else?____________________

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have your wisdom teeth? ☐ Yes ☐ No

Previous / Present Dentist?_______________ Last Visit Date?__________

(Please Circle)

Would you like fresher breathe? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change?______________________________

____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:______________________________

Address: ______________________________

____

Phone ( ) _______________ Date of last visit: _______________

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain?______________________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week# ________ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hey Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: ______________________________

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No If yes list each on:______________________

____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Eryghromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry/ Metal	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions:______________________________

____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary service I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely permanent numbness. I understand that occasionally needles break and may require surgical retrieval.
I have received a copy of this offices Notice of Privacy Practices.

____

Signature Date

ALGEO FAMILY & IMPLANT DENTISTRY

1406 N Sioux
Claremore, Oklahoma 74017
918-341-6573

Patient Name: ______________________________ Date: _____________

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Dr Clay Algeo.
- I may refuse to sign.
- Expiration: 3 years from initial/last signature; insurance change; patient reaches age of 18.

- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: ____________________ Relationship: _________ Phone: ____________

Name: ____________________ Relationship: _________ Phone: ____________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION AND INFORMATION ABOUT MY DENTAL HEALTH** VIA:

- ☐ Message on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- ☐ Text
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ Any of the above

_________________________________ _________________________________
Please ***print*** your name Please ***sign*** your name

☐ Patient ☐ Parent ☐ Guardian ☐ Other _________________________

Algeo Family & Implant Destistry
1406 N. Sioux
Claremore, OK 74017
918-341-6573
Brush3x@gmail.com

Patient's / Parent Name: ______________________ Date of Birth ______________

Dependents: ______________________ Date of Birth ______________

______________________ Date of Birth ______________

______________________ Date of Birth ______________

______________________ Date of Birth ______________

Person legally responsible for making treatment decisions and financial arrangements:

Name: ____

Address: ______________________ City: ____________ State: ______ Zip: __________

Email Address: ____

We appreciate your selection of our dental office to serve your dental health care needs. We are committed to providing the highest quality dental care, so that you may obtain optimal oral health.

The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Missed Appointments: Time is reserved especially for you with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for your convenience and hold great value. We require at least 24 hours notice if cancellation is necessary. Habitual last minute cancellations will result in a required deposit to schedule future appointments.

Please Note: Payment is due at time of service. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. If insurance benefits apply, **estimated patient co-payments** and **deductibles** are due at time of service. Any remaining balance after insurance is processed is you responsibility.

Insurance Benefits: We will be happy to assist you in maximizing your insurance benefits, however, we would like to emphasize that insurance is an agreement between you and your insurance company. Upon request, we will provide you with estimates for your treatment to the best of our ability. Please understand this is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. We will do all we can to ensure your estimate is as accurate as possible, but keep in mind it is an estimate only. Your estimated insurance benefits may differ due to a number of reasons, specifically related to your plan.

All charges incurred are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company.

Consent:
I have read, understand and agree to the above terms and conditions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signature of the person legally responsible for making treatment decisions and or financial arrangements:

____ Date: ______________