BA-dentist.com
1100 East Lansing Street
Broken Arrow, OK 74012

Patient Information: Please completely answer the following information.

Name:_____ Date: _____
Last First Middle
□ Male □ Female □ Single □ Married, Spouse: _____ □ Child, Parents: _____

Address:_____ City: _____ State: _____ Zip: _____
Street Apt #

Home Phone: _____ Cell Phone: _____ Work Phone: _____ext_____

Social Security Number: _____ Birthdate: _____ E-mail Address: _____

Employer: _____ Employer Address:_____ City:_____ Zip:_____

If full time student, school name: _____ Grade:_____

Person Responsible for Account: □ Patient □ Mother/ Father □ Spouse □ Guardian

Name: _____ □ Male □ Female □ Single □ Married, Spouse:_____
Address: _____ City: _____ State: _____ Zip: _____
Street Apt #
Home Phone: _____ Cell Phone: _____ Work Phone: _____ext_____
Social Security Number: _____ Birthdate: _____ E-mail Address:_____
Employer: _____ Employer Address:_____ City:_____ Zip:_____

Emergency Contact Not Living With You:

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ext_____

Insurance Information: Please completely answer the following information.

Primary Insurance

□ Patient □ Mother/ Father □ Spouse □ Other_____
Name: _____
Last First Middle
SS#: _____ Birthdate: _____
Employer: _____
Insurance Co.: _____ Group #: _____
Ins. Co. Phone: _____ ID#: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ E-mail: _____

Secondary Insurance

□ Patient □ Mother/ Father □ Spouse □ Other_____
Name: _____
Last First Middle
SS#: _____ Birthdate: _____
Employer: _____
Insurance Co.: _____ Group #: _____
Ins. Co. Phone: _____ ID#: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ E-mail: _____

Insurance Disclaimer:

Dental insurance plans have exclusions, these help to keep premiums as low as possible for your employer. This makes your dental plan a supplemental coverage for your dental needs, and not designed to cover your treatment in its entirety. Dr. Gentling's goal is to identify, recommend and treat your dental needs in your best interest. _____
Please initial

We do require that if patient is a child under the age of 18 a parent or guardian must accompany patient for all appointments for consent of treatment. _____
Please initial

Payment and Treatment Authorization:

I hereby authorize and give consent for payments to be made directly to BA-dentist.com. ***I understand that I am responsible for all dental treatment costs regardless of any insurance coverage.*** I hereby authorize BA-dentist.com to administer medications and perform diagnostic, photographic and therapeutic procedures as may be necessary for my proper dental care. All information provided by me on my patient information, health history and dental history forms are correct to the best of my knowledge. I grant the right to BA-dentist.com to release my dental/ medical and patient information to third party payers and/ or other health professionals. I understand BA-dentist.com works with the District Attorneys office when fraudulent funds are issued. Services charges may apply to my account in addition to any NSF Check Fee. In the case of default of payment, I promise to pay any legal interest on the balance due, together with collection costs and just attorney fees incurred to collect on my account or future outstanding accounts.

Signature: _____ **Date:** _____
Patient or Responsible Party
Drivers License Number: _____**State:** _____**Expiration Date**: _____

Patient Name:_____ **Date:**_____
Last First Middle

Health History:

Do you have or have you ever had any of the following?

Diabetes	**Y/ N**	Cancer Treatment _____	**Y/ N**
Lupus	**Y/ N**	Asthma	**Y/ N**
AIDS/ HIV Positive	**Y/ N**	Epilepsy/Seizures	**Y/ N**
Artificial Joints_____	**Y/ N**	Hepatitis A, B or C, circle which one	**Y/ N**
Artificial Heart Valves	**Y/ N**	Osteoporosis	**Y/ N**
		High Blood Pressure	**Y/ N**

***WOMEN*:**

Are you Pregnant? **Y/ N** **Due Date: _____** Take Bisphosphonate? **Y/ N**

****

Do you smoke or use tobacco products? If yes, explain _____ **Y/ N**
Are you taking blood thinners or aspirin? If yes, explain_____ **Y/ N**
Have you been hospitalized or had surgery in the last two years? **Y/ N**
Explain: _____
Do you have any other disease, condition or problem not listed that the doctor should know about? **Y/ N**
Explain:_____
Are you currently taking any medications? **Y/ N**
Please list:_____
Do you have any medication allergies? **Y/ N**
Please list:_____
Are you currently under the care of a primary care physician or a specialist? **Y/ N**
Explain & list below:_____

PCP Name: _____ Clinic:_____ Phone: _____

How did you learn about us? _____
How long has it been since your last dental visit? _____Reason: _____
What is the reason you left your previous dentist?_____
Reason for today's visit? _____
Are there any areas of concern you have regarding your mouth? _____

Do you have any *family history* of periodontal disease/conditions? **Y/ N**
Have you ever been told you have gum disease or periodontal disease? **Y/ N**
Have you ever had a deep cleaning/ scaling and root planing? **Y/ N**
If so, when? _____
Do your gums bleed when you brush or floss? **Y/ N**

How nervous are you about dental treatment?

Not at all 1 2 3 4 5 6 7 8 9 10 Extremely Nervous

I certify to the above statements regarding my medical and dental conditions that the information provided is complete and accurate.

Signature: _____ **Date:** _____
Patient or Responsible Party

Thank you for choosing BA-dentist.com. We want your visit to be pleasant and comfortable.

Office Use Only

☐ Posted _____
Reviewed By: _____ Date: _____
Information Received
☐ Insurance Card _____
☐ Drivers License _____

Patient Name:_____ **Date:**_____
Last First Middle

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the notice.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Consent for Release of Medical Information

I hereby grant BA-dentist.com permission to contact me and leave messages pertaining to my dental care (including calling to remind me of appointments, to inform me of referral appointments, test results, prescription information, etc.) by a recording device or with the following persons (please consider listing spouse, parents, step-parents, grandparents, children, secretary, etc)

Name: _____ **Name**: _____

Name: _____ **Name**: _____

This consent will remain in effect throughout our dentist-patient relationship unless withdrawn in writing by patient. I am aware that signing this form may cause disclosure of confidential or privileged information to those designated by me. I have been given the opportunity to read the consent and receive clarification of any questions I may have, and to obtain a copy.

Consent of Reviewed Office Polices

I have had an opportunity to review a copy of BA-dentist.com office policies. I understand that I may request a copy. Information included the following:

1. How we work with insurance companies
2. Payment Options
3. **48 hour Cancellation Policy**
   * Confirmation by returning our phone call is required to keep your reserved appointment date and time
4. **Confirmation of Appointments**
   ***** We give a courtesy call 24 to 48 hours in advance of your appointment.
   * We will call your phone numbers and leave a message for you to call us back to confirm your reserved appointment.
   * ***Confirmation by returning our phone call is required to keep your reserved appointment date and time***.

Signature: _____ **Date:** _____
Patient or responsible party

BA-DENTIST.com
TODD A. GENTLING, DDS
1100 East Lansing Street
Broken Arrow, OK 74012
918-251-8141

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have received a copy of Dr Gentling's Notice of Privacy Practices.

_____
Please Print Name

_____
Patient Signature (Parent/Guardian Signature if under 18)

_____
Date

Form expires 3 years from today's date _____

I agree to notify of any change in insurance coverage _____

I consent for the office of Dr Gentling to share my personal information with the following: (family, friends, etc)

Name / Relationship:

1. _____ / _____
2. _____ / _____
3. _____ / _____
4. _____ / _____

Date _____

Signature _____