OZARK
PROSTHODONTICS

Welcome! We are so glad that you are here. Please complete this form and bring it with you so we can provide you with the best possible care.

8028 Cantrell Road
Little Rock, AR 72227
Phone: (501) 319-7520

Patient Name _____ **Date of birth**_____

DENTAL HISTORY

What is the reason for your visit today? _____
Who referred you to our office? _____
Date of last dental visit_____ Last dental cleaning_____ Last full mouth x-rays _____
Name of general Dentist_____
Address:_____ State:_____ Zip:_____
How often do you have dental examinations?_____ How often do you brush your teeth? _____
How often do you floss?_____ What other dental aids do you use?_____
Describe your current dental problems_____

Are any of your teeth sensitive to hot, cold, or sweets?	YES	NO
Are any of your teeth sensitive to biting or chewing?	YES	NO
Have you noticed any mouth odors or bad tastes?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth or change in your bite?	YES	NO
Does food tend to get caught in between your teeth?	YES	NO
Do you clench and grind your teeth while awake or asleep?	YES	NO
Do you bite your lips or cheeks regularly?	YES	NO
Do you hold foreign objects with your teeth?	YES	NO
Do you mouth breath while awake or asleep?	YES	NO
Do you have tired jaws, especially in the morning?	YES	NO
Do you smoke or chew tobacco?	YES	NO
Do you have dentures?	YES	NO
Have you ever had orthodontic treatment?	YES	NO
Have you ever had oral surgery?	YES	NO
Have you ever had Periodontal treatment?	YES	NO
Have you ever had your bite adjusted?	YES	NO
Have you ever had a mouth guard or bite plate?	YES	NO
Have you ever had a serious injury to the mouth or head?	YES	NO
Have you experienced clicking or popping of the jaw?	YES	NO
Have you experienced pain in the joint, ear, or side of face?	YES	NO
Have you experienced trouble chewing on either side of your mouth?	YES	NO
Have you experienced headaches, neck aches, or shoulder aches?	YES	NO
Have you experienced sore muscles in your shoulders or neck?	YES	NO
Are you satisfied with your teeth's appearance?	YES	NO
Would you like to keep all your teeth all your life?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
Have you ever had an upsetting dental experience?	YES	NO

Is there anything else about having dental treatment that you would like us to know? _____

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MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years?..... YES NO
If yes, for what? _____
Physician's name:_____ Phone:_____
Address:_____City:_____ State:_____ Zip:_____
Have you been a patient in the hospital during the past five years? If yes, why?_____
Are you aware of having an allergic or adverse reaction to any medication or substance?_____
Are you currently taking medications? If yes, what is the name and dosage?_____
Have you had any surgeries in the last five years?_____

***Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item. ***

Heart surgery	YES NO	Artificial joint	YES NO	Do you see a cardiologist	YES NO
A-Fib	YES NO	Swollen ankles	YES NO	Been Prescribed bisphosphonates	YES NO
Cardiac stents	YES NO	Spine Injuries	YES NO	A.I.D.S	YES NO
Chest Pain	YES NO	Restricted diet	YES NO	H.I.V positive	YES NO
Congenital Heart Disease	YES NO	Ulcers	YES NO	Hepatitis A or B	YES NO
Heart murmur	YES NO	Glaucoma	YES NO	Been prescribed methotrexate	YES NO
High Blood Pressure	YES NO	Chronic cough	YES NO	Any anesthesia complications	YES NO
Mitral Valve Prolapse	YES NO	Tuberculosis	YES NO	Sleep Apnea	YES NO
Artificial Heart Valve	YES NO	Asthma	YES NO	GERD/Acid reflux	YES NO
Heart Pacemaker	YES NO	Hay fever	YES NO	Shortness of breath	YES NO
Rheumatic fever	YES NO	Latex sensitivity	YES NO	Psychiatric/psychological care	YES NO
Arthritis Rheumatism	YES NO	Allergies or hives	YES NO	Nervous or anxious	YES NO
Stroke	YES NO	Sinus trouble	YES NO	Neurological disorders	YES NO
Kidney Trouble	YES NO	Radiation therapy	YES NO	Tetracycline staining	YES NO
Diabetes	YES NO	Chemotherapy	YES NO	Pain management contract	YES NO
Thyroid Problems	YES NO	Bruise easily	YES NO	Dry mouth	YES NO
Tumors	YES NO	Cold sores/fever blisters	YES NO	Hyperactive gag reflex	YES NO
Hemophilia	YES NO	Fainting/dizzy spells	YES NO	Sleep with more than two pillows	YES NO
Sickle Cell Disease	YES NO	Blood transfusions	YES NO	Lost or gained more than 10 pounds	YES NO
Epilepsy or Seizures	YES NO	Liver Disease	YES NO	Face pain related to a tooth	YES NO

Women: Are you pregnant: YES, ____months NO Nursing? YES NO Taking birth control pills? YES NO

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

*Patients/Guardian's Signature: _____ Date: _____

History Review

Dentist Signature: _____ Date: _____

PATIENT INFORMATION

DATE _____
LAST NAME_____
FIRST_____ M.I. _____
PREFERS TO BE CALLED BY _____
ADDRESS_____
CITY_____STATE____ZIP_____
HOME PHONE NO_____ FAX_____
CELL_____
BIRTHDATE_____AGE_____MALE___FEMALE
MARRIED___SINGLE___DIVORCED___WIDOWED
SOCIAL SCURITY NO_____
EMAIL ADDRESS_____

OCCUPATION_____
EMPLOYER'S NAME_____
ADDRESS_____
CITY_____
PHONE NO_____FAX NO_____
YOU WERE REFERRED TO US BY_____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME_____
RELATIONSHIP TO PATIENT_____SSN_____
ADDRESS_____
CITY_____STATE____ZIP_____
PHONE NUMBER_____FAX_____
CELL_____EMAIL_____
OCCUPATION_____
EMPLOYER'S NAME_____
ADDRESS_____CITY_____
PHONE NO_____ FAX NO_____
CELL_____EMAIL_____

FAMILY INFORMATION

Is another member of your family or relative a patient at our office?

NAME_____
RELATIONSHIP_____

Person to contact for emergency_____
PHONE NUMBER_____
ADDRESS_____
CITY_____ STATE_____ZIP_____
Closest relative not living with you_____
PHONE NUMBER_____
ADDRESS_____
CITY_____STATE_____ZIP_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½ % late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

PATIENT'S SIGNATURE_____
DATE_____WITNESS_____
PATIENT'S/RESPONSIBLE PARTY'S SIGNATURE_____
RELATIONSHIP TO PATIENT_____

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment.

For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may provide you with a report of your progress for your insurance company if applicable.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may provide you with appointment reminders such as postcards and/ or a phone call. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. If this practice is sold, your information will become the property of the new owner.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes your request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

ACKNOWLEDGEMENT (Please note: You may refuse to sign this acknowledgement)

I have received a copy of the Notice of Privacy Practices. Date: _____

Signed: _____ Print Name: _____

If signing as a parent or guardian, please note the name of the patient _____

Thank you, and if you have any questions about this form or the Privacy Practices, please contact our privacy officer.

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patient's (or representative's) signature on the Acknowledgement but did not because _____ It was emergency treatment, _____ I could not communicate with the patient ___, The patient refused to sign____, The patient was unable to sign because: _____

Other (please describe) _____

Signature of Privacy Officer_____

OZARK
PROSTHODONTICS

ADVANCE NOTICE FOR CANCELLATION AGREEMENT

Our practice is committed to providing exceptional oral health care in a timely manner. Due to the nature of a prosthodontic practice, a significant number of our patients present with comprehensive dental problems, which dramatically affect their quality of life. It is our mission to improve these situations with, proper conscientious care. Therefore, it is very important that we respect all scheduled appointments. These appointments are considered confirmed at the time they are made. We will call you one, as a courtesy, to remind you of the appointment. Because a substantial amount of time has been set aside for you, we will charge $50 per hour for appointments missed with the doctor and $25 per hour for appointments missed with the hygienist. Please contact the office two business days in advance, if you need to reschedule, to avoid this charge.

Thank you for your understanding in this matter.

Signature of patient or responsible party: _____ Date: _____

Office hours: Monday-Friday 8:00-5:00

FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to excellence in providing the finest service available for all of our patients. Good communication concerning dental problems, treatment solutions, and payment arrangements is of primary importance to accomplish this goal. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

We understand that dental insurance is an important factor for patients to consider when entering treatment. Please also understand that our treatment recommendations are based entirely upon what is best for your oral health, and not the coverage terms of any particular insurance plan. Your insurance policy is a contract between you and your insurance company, not your doctor. Most dental plans are designed to assist with limited treatment or routine maintenance, and usually carry an annual maximum. They are not designed to cover comprehensive treatment, regardless of the medical necessity.

For patients with insurance, we will be happy to provide a receipt at the end of your visit, which will enable you to file your own claim with your insurance company. You are responsible for payment in full for services rendered without regard to insurance coverage. Before beginning treatment, you are entitled to, and will be provided, a detailed treatment plan showing the number of appointments and cost of services at each. Payment for services may be made in one of the following ways:

1. Pay at each visit for services completed that day with cash, check, MasterCard, Visa, American Express, or Discover.

2. For treatment amounts over 10,000, you may receive a 5% discount when paying in full by cash or check on or before your first visit.

3. Extended financing through a third-party dental financing company. Rates and terms furnished upon request.

These policies allow us to focus all of our efforts on providing superior oral health care. We want you to be comfortable in dealing with these matters. Please ask if you have any questions regarding treatment procedures, fees, or payment options. Thank you for your understanding.

Signature of patient
Or responsible party: _____ Date: _____

OZARK PROSTHODONTICS

8028 Cantrell Road
Little Rock, Arkansas 72227
501-319-7520

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

PRINTED NAME: _____ DATE: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Ozark Prosthodontics' Notice of Privacy Practices.

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

Expiration – 3 years from Initial Signature; Insurance Change; Patient reaches age of 18

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

Name / Relationship / Phone

_____ / _____ / _____

_____ / _____ / _____

Signature: _____

☐ Patient ☐ Parent ☐ Guardian / Other

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PHOTOGRAPHY/IMAGING CONSENT FORM

I consent for medical imaging (photo, video, radiographic images and/or audio) to be made of **myself** or **my child** (or for person whom I am legal guardian). I understand that the information from my medical records may be used for purposes of teaching, publication, or marketing, advertising, and media (including websites, printed materials, news reporting, documentary films, commercials, television or film, social media, websites, etc.).

By consenting to this, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recording will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the staff at Ozark Prosthodontics.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

_____ _____

Signature Date

_____

Printed Name

OZARK
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SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **PROCESS ALL INSURANCE CLAIMS:**
2. **ENSURE PAYMENT FOR SERVICES PROVIDED**
3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS**
4. **RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Persenaire, Dr. Sinada, Dr. McNeel, Dr. Wang, and/or Dr. Miller at Ozark Prosthodontics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____

Patient Full Name (printed) _____

Parent Signature (if minor) _____

Witness _____

Date Signed _____