Philip Norman Ralph Estes, DDS
Reemon Yousif Ashoty, DDS
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oakdental
Frisco

Appointments: (972) 335-4145
Fax: (972) 335-1019
info@oakdentalfrisco.com

1 Patient Information

Today's Date: _____/_____/_____

Patient Name: _____
Last First MI

What do you prefer to be called: _____

Male ___ Female ___

Birth date: ___/___/_____ Age: _____ SS#: _____

Mailing Address: _____

_____
City State Zip

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

Email Address: _____

How did you find us?_____

Employer: _____ How Long? _____

Employer's Address: _____

_____
City State Zip

Occupation: _____

Status: __ Minor __ Single __ Married __ Divorced
__ Separated __ Widowed

Spouse's Name: _____

How would you prefer to be contacted with appointment reminders?
___Home Phone ___Cell Phone ___Text ___Email

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____

Phone #: _____

Insured's ID#: _____

Group # (Plan, local, or policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Does your policy cover Orthodontics? __ Yes __ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____

Phone #: _____

Insured's ID #: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/_____

Insured's Employer: _____

Does your policy cover Orthodontics? __ Yes __ No

3 In Event of Emergency

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor: _____

Medical Doctor's Phone #: (_____) _____

4 Account Info (if patient is a minor)

Name: _____ Relation: _____

Billing Address: _____

_____

SS #:_____Driver's License #:_____

Phone #: (_____) _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Patient Name: _____

5 Dental Info

Reason for today's visit: ___ Exam ___Cleaning ___ Emergency ___ Consultation
Are you in pain? ___ No ___ Yes For how long? _____
Please indicate with a check any of the following problems:

___ Discomfort, clicking or popping in jaw
___ Red, swollen or bleeding gums
___ Sensitive tooth, teeth or gums
___ Blisters/Sores in or around the mouth
___ Lost/ Broken Fillings(s)
___ Teeth grinding
___ Ringing in Ears
___ Broken/ Chipped tooth
___ Stained teeth
___ Locking Jaw
___ Bad breath
___ Missing Teeth

Other problems/Primary Concern: _____
Do you require pre- medication? ___ Yes ___ No ___ Not Sure
Previous Dentist: _____ (____) _____
Name Phone #
Last Dental Exam ____/____/_____ Last Dental X- rays: ____/____/_____
Times a day you brush? _____ Times a week you floss? _____
What type of tooth brush bristles do you use? ___ Soft ___ Medium ___ Hard
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Explain: _____

6 Medical History

Date of last physical exam: ____/____/_____
Date of last tetanus shot: ____/____/_____
Are you taking any of the following medications? ___ Nerve pills ___Insulin ___Antibiotics ___Heart Pills
___ Pain killers (including aspirin) ___ Muscle Relaxers ___Stimulants ___Blood Thinners ___Tranquilizers
___Other (s), please list _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y or N Alcohol / Drug Abuse	**Y or N** Chronic Pain	**Y or N** Glaucoma	**Y or N** Pre-medication ABX
Y or N Anemia	**Y or N** Congenital Heart Defect	**Y or N** Heart Attack	**Y or N** Psychiatric Problems
Y or N Arthritis / Rheumatism	**Y or N** Cosmetic Surgery	**Y or N** Heart Disease	**Y or N** Radiation Therapy
Y or N Artificial heart Valves	**Y or N** Dental Phobia	**Y or N** Heart Surgery/Pacemaker	**Y or N** Respiratory Problems
Y or N Artificial joints	**Y or N** Diabetes / Hypoglycemia	**Y or N** Hepatitis (A, B, or C)	**Y or N** Sinus Problems
Y or N Asthma	**Y or N** Difficulty Breathing	**Y or N** High Blood Pressure	**Y or N** STD
Y or N Bleeding Problems	**Y or N** ED drug usage/Viagra	**Y or N** HIV+/AIDS/ARC	**Y or N** Stomach Problem/GERD
Y or N Cancers / Tumors	**Y or N** Emphysema/COPD	**Y or N** Kidney Problems	**Y or N** Stroke
Y or N Cerebral Palsy	**Y or N** Epilepsy / Seizures	**Y or N** Leukemia	**Y or N** Thyroid Problems
Y or N Chemotherapy	**Y or N** Fainting	**Y or N** Liver Problems	**Y or N** TMJ / Jaw Problems
Y or N Chest Pains	**Y or N** Flu Virus Exposure	**Y or N** Low Blood Pressure	**Y or N** Tuberculosis TB

*** Please list any other surgeries or medical conditions you have or ever had and dates:
_____

*** **Are you allergic to any of the following?** ___ Latex ___ Penicillin ___Amoxicillin ___Codeine ___Vicodin
___ Sulfa ___Ibuprofen/Motrin/Advil ___Aspirin ___Dental Anesthetics ___None ___Other: _____
Do you use tobacco? ___No ___Yes How used? _____ How much? _____ How long? _____
Please rate your general health from 1-10: _____ Do you wear contact lenses? ___ Yes ___No
Have you ever taken herbal or homeopathic medicines? ___ Yes ___ No
For Women: Are you taking Birth Control pills? ___ Yes ___ No How many children have you had? _____
Are you Pregnant? ___ No ___Yes/How long? _____ Are you nursing? ___ Yes ___ No

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

- I understand that the Oak Dental Frisco policy requires payment in full for all services rendered at the time of visit. No personal checks will be accepted. I will pay by cash or major credit card. If desired for future payments I will request information about Care Credit. There will be no exceptions to this policy.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims, or to coordinate treatment with other health care professionals to include physicians and dental specialists.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/_____
___ Adult Patient ___ Parent or Guardian ___ Spouse

Witness Name and Signature _____ Date ____/____/_____

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Appointment Cancellation Policy

Your appointment time is important to you, your dentist and to others who are in need of our services.

If you find it necessary to cancel or change your appointment date, please call us 48 hours prior to your appointment time. If you do not show for your appointment or cancel with less than 48 hours notice and it is not an emergency situation, **a fee of $50 will be charged to your account.** You will be personally responsible for this charge. This charge will not be billed to nor paid for by your insurance company. Future appointments will not be scheduled until this fee is paid.

Please help us keep the scheduling of appointments fair for everyone. Thank you.

_____
Patient Name

_____ _____
Patient/Guardian Signature Date

_____
Witness

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Oak Dental Frisco PLLC has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Oak Dental Frisco PLLC reserves the right to change the Notice of Privacy Policies.
- Oak Dental Frisco PLLC has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Oak Dental Frisco PLLC may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

Patient Name	Guardian Name/Relationship
Patient/Guardian Signature	Date
Witness Signature	Date