

PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name: Last		First		Middle	
Address: Street or P.O. Box #		City		State Zip code	
				Phone Number: Home: Work:	
Cell Phone:		Email Address:			
Age: Yrs.	Birth Date: Month Day Year			() Married () Unmarried () Separated	
Social Security No:		Driver's License No:			
Occupation:	Employer:		How long employed?	Address & Phone No:	
Person responsible for bill:	Age:	Address:		Relationship:	Social Security No: Driver's License No:
Occupation:	Employer:			How long Employed?	
Employer Address & Phone No:					

Insurance Information

Insured Person's Full Name		Date of Birth	
Social Security Number	Relationship to Patient		Work Phone
Insurance Company Name	Group or Union Name		Group or Local Numbers
Employer's Name		Full Address of Employer	

Getting to Know You

<p>1. Why did you select our practice? _____ _____</p> <p>2. Whom may we thank for referring you? _____</p> <p>3. Is another member of your family or relative a patient in our practice? _____</p> <p>4. Person to contact for emergency: _____ Phone: _____</p>	<p>5. When was your last dental visit? _____</p> <p>6. When was the last time you had complete dental radiographs taken? _____ Name and Address of last Dentist: _____</p> <p>7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants</p>
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Payment Alternatives

Please check appropriate box:

<p><input type="checkbox"/> 1. Cash and personal checks are accepted as your treatments are provided.</p> <p><input type="checkbox"/> 2. Mastercard, Visa, Discover and American Express</p> <p><input type="checkbox"/> 3. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.</p>	<p><input type="checkbox"/> 4. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.</p> <p>This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.</p>
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FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party

Relationship

Date



MEDICAL HISTORY

1. Are you having dental problems at this time?..... Yes No
2. Do your gums bleed at any time?..... Yes No
3. Do you feel very nervous about having dental treatment?..... Yes No
4. Have you ever had a bad experience in the dental office?..... Yes No
5. Have you been under the care of a medical doctor during the past two years?..... Yes No

If yes: for what reason? _____
 Please provide the name, address, and telephone number of your physician.

6. Have you been a patient in the hospital during the past two years?..... Yes No
 If yes: for what reason? _____
7. Have you taken any prescription or non-prescription medicine/drugs during the past two years? If yes, please list:..... Yes No

8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:..... Yes No

9. Do you have an artificial joint of any type? Yes No What joint and when replaced? _____

10. Have you ever had excessive bleeding requiring special treatment?..... Yes No
11. Do you use any tobacco products?..... Yes No
12. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... Yes No
13. Do your ankles swell during the day?..... Yes No
14. Have you lost or gained more than 10 pounds in the last year?..... Yes No
15. Do you use more than 2 pillows to sleep?..... Yes No
16. Do you ever wake up from sleep short of breath?..... Yes No
17. Are you on a special diet?..... Yes No

Check any of the following which apply in either past or present:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Valve Prolapse
<input type="checkbox"/> Heart Failure
<input type="checkbox"/> Heart Disease or Attack
<input type="checkbox"/> Family History of Cardiovascular Disease
<input type="checkbox"/> Angina Pectoris (chest pain)
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Congenital Heart Lesions
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Heart Pacemaker
<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Diet Medication: Name _____ | <input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Allergies or Hives
<input type="checkbox"/> Fainting or Dizzy Spells
<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Any Form of Eating Disorder
<input type="checkbox"/> Recreational Drug Use
<input type="checkbox"/> Drug Addiction/Alcoholism
<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cortisone or Steroid Medication
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Cancer or Tumors
<input type="checkbox"/> Chemotherapy or Radiation Tx
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> HIV Positive (AIDS)
<input type="checkbox"/> Cold Sores or Fever Blisters
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Any Form of Hepatitis
<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke
<input type="checkbox"/> Birth Control Medication
<input type="checkbox"/> Pregnant – Due Date _____ |
|---|---|---|

18. Do you have any disease, condition or problem not listed? If so, please list..... Yes No

Doctor's Signature: _____ Date Reviewed: _____



CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist of Dr. Jana Oister and/or dental auxiliaries of her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anaesthesia, radiographs (x-rays), or diagnostic aids.
 - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
 - D. Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants).
 - E. Removal (extraction) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and/or soft).
 - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
 - H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
 - I. Use of general anaesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that this risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anaesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anaesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that either are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instruction of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____ AM/PM File No. _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

Signature: Patient or Parent or Guardian _____

Witness: _____

Dr. Jana Oister
204 Southgate
Cherokee, OK

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(580)596-3541 phone
jko@sbcglobal.net email





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204 Southgate
Cherokee, OK 73728

Contact Information For Protected Health Information

I, _____, Date of Birth: _____,
request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es) tests results, dates of service.

Please Check All That Apply

- You may disclose information to my family members and/or non-family members. Please list name, phone number and relationship.

Name	Phone Number	Relationship

- You may leave Protected Health Information on my answering machine/voicemail/email.

Phone Number: _____

Email: _____

- Other: _____

- You may disclose insurance information to a referring dental office.

Patient's Signature: _____ Date: _____

Patient's Printed Name

Social Security Number

Patient's Signature (or Guardian, if minor)

Date

Witness (optional)

Date



(580)596-3541 phone
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www.jkofamilydentistry.com
204 Southgate
Cherokee, OK 73728

Notice Of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of JKO Family Dentistry's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify)

To be retained in patient's file.



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Smile Evaluation

1. Do you like the way your teeth look? Yes ____ No ____
Explain _____
2. Are you happy with the color of your teeth? Yes ____ No ____
Explain _____
3. Would you like your teeth to be whiter? Yes ____ No ____
Explain _____
4. Would you like your teeth to be straighter? Yes ____ No ____
Explain _____
5. Do you have spaces between your teeth you would like closed?
Yes ____ No ____
If so, where? _____
6. Would you like your teeth longer? Yes ____ No ____
If so, Upper ____ Lower ____
7. Do you have missing teeth you would like replaced? Yes ____ No ____
Explain _____
8. Do you like the shape of your teeth? Yes ____ No ____
Explain _____
9. Do you have old silver fillings you would like replaced with tooth-colored fillings? Yes ____ No ____
Explain _____
10. If you could change anything about your smile, what would you change?
Explain _____

I agree to let Dr. Jana Oister's team to take photos of me to utilize for educational or promotional purposes.

Signature: _____

Date: _____