PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

PATIENT DENTAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH.	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY.	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

SIGNATURE DATE

PATIENT NUMBER

HEALTH HISTORY

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	☐ ☐	☐ ☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. DO YOU USE TOBACCO	☐	☐
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
15. ARE YOU WEARING CONTACT LENSES	☐	☐
16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

ITEM 07-0515775/27011 COLWELL 1.800.637.1140

PATIENT NUMBER

HEALTH HISTORY

HIPAA PRIVACY

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____(the "Patient" or "Patient's" legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of *Jeffrey F. Hermen, D.D.S.* and have been offered a copy of such policy to keep for my records.

_____ (Please initial here) I hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____ (Please initial here) I hereby acknowledge that I have read the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide treatment to me.

_____ _____

Signature of Patient/Legal Representative Date

For Office Use Only

I, _____ acting as _____ for Provider attempted to obtain the written acknowledgment of receipt of the Policy of Provider on _____, but acknowledgment could not be obtained because:

_____ (Please initial here) Patient or Patient's legal representative refused to sign.

_____ (Please initial here) Patient or Patient's legal representative could not be communicated with sufficiently to obtain acknowledgment.

_____ (Please initial here) Emergency circumstances prevented securing acknowledgment.

_____ (Please initial here) Other (Please specify)

_____

_____

_____

_____

_____ _____

Signature of Provider Representative Date

Jeffrey Hermen, D.D.S.

Comprehensive Dental Care

It is time to update your health history.

Please include a current copy of your medications and surgeries for our records.

You may mail, fax or email it to our office.

Thank you,

Jeffrey F. Hermen, D.D.S.

13304 N. MacArthur Blvd

Oklahoma City, OK 73142

Telephone 405-621-2100

Fax 405-621-2110

info@hermendental.com

Insurance Acknowledgement

As part of our commitment to you, we want to assist you in maximizing the benefit from your dental insurance while providing the best possible care. To help you make informed treatment decisions with respect to your insurance, please be aware of the following:

- As the insured, only you have complete access to the terms of your policy.
- Our office is not a party to the contract between you and your insurance company and is given only limited coverage information by your carrier.
- Our office will verify coverage at your first visit. Please notify us if your insurance changes.
- Our office is not responsible for incorrect or incomplete information provided by your insurance company.
- As a courtesy to you, we will file your claim and take assignment of benefits.
- Payment will be requested from the patient on claims not paid within a reasonable time period (normally 60 days).
- You are responsible for all fees not covered by your insurance company for any reason.
- Be proactive! Call your insurance company to check the status of claims not promptly paid.
- Know your insurance.
  -request printed coverage terms from your insurance carrier
  -understand your benefit maximum limits, co-payments, waiting periods, exclusions, etc.

Patient Acknowledgement

I have read the above information and accept the terms for assignment of insurance benefits to this office.

_____ _____

Patient signature date

Thank you for allowing us to serve you, and for helping in our efforts to have your insurance claims processed as quickly and accurately as possible.

Jeffrey F. Hermen, D.D.S. and team