Dr. Deren Flesher, DDS
7101 NW 150th St. Ste. 100
Oklahoma City, OK 73142
T (405) 896.7997 · F (405) 896.7991

Patient Information

We are pleased to welcome you to our office! Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we'll be glad to help you. All required signatures are highlighted in YELLOW.

PATIENT INFORMATION			
Name:			Preferred Name:
Birthday:	SSN:		Gender: ☐ Male ☐ Female
Current address:			
City:	State:		ZIP Code:
Married: ☐ Yes ☐ No	Work #:		Cell #:
E-Mail:			Home #:
Student status if dependent over 19 for insurance:	☐ Non-student ☐ Full-time ☐ Part-time		Wireless carrier:
Preferred method of contact:	☐ Home Phone #	☐ Work Phone #	☐ Cell Phone # ☐ E-Mail
Preferred contact for appointment confirmations:	☐ Home Phone #	☐ Work Phone #	☐ Cell Phone # ☐ E-Mail
Preferred contact for return appointments:	☐ Home Phone #	☐ Work Phone #	☐ Cell Phone # ☐ E-Mail
How did you hear about Royal Oak Family Dental?	☐ Mail flyer ☐ Driving by office ☐ Online search	☐ Billboard ☐ Live in the area ☐ Facebook	☐ Referred by friend/family/co-worker **Please let us know who you were referred by so we can thank them:*

INSURANCE POLICY 1	
Your relationship to the primary subscriber: ☐ Self ☐ Spouse ☐ Child	Primary subscriber name:
Subscriber ID# or SSN:	Insurance company:
Subscriber birthday:	Employer:
Insurance phone #:	Group #:
Group Name:	***Please present your insurance card & photo ID to Front Desk***

INSURANCE POLICY 2	
Your relationship to the primary subscriber: ☐ Self ☐ Spouse ☐ Child	Primary subscriber name:
Subscriber ID# or SSN:	Insurance company:
Subscriber birthday:	Employer:
Insurance phone #:	Group #:
Group Name:	***Please present your insurance card & photo ID to Front Desk***

FINANIAL AGREEMENT

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

- **We require at least a deposit of 25% on all treatment appointments. This amount will be applied to your out-of-pocket expenses not covered by your insurance. These deposits must be made prior to scheduling the appointment.**
- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- I agree to let this office run a credit report. If no, then all fees are due at time of service. ☐ Yes ☐ No
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- I will pay a fee for appointments broken without 24 hours' notice.
- Treatment plans may change, and I will be responsible for the work actually done.
- A fee of $25.00 will be charged on all returned checks.

Signature: **Date:**

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MEDICAL HISTORY			
Name of medical doctor:		City/State:	
Emergency contact:	Phone #:	Relationship:	
List all the medications or drugs you are <u>now taking</u>: ☐ None		**List all the medications or drugs you are <u>allergic to</u>: ☐ None**	
List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen. ☐ None			
Unusual reaction to dental injections? ☐ No ☐ Yes		Are you in pain? ☐ No ☐ Yes	
Reason for today's visit:		Date of last cleaning & exam:	
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ☐ No ☐ Yes			Tobacco use? If yes, what kind & how much? ☐ No ☐ Yes
Do you have BiteWing x-rays that are less than 1-year-old? ☐ No ☐ Yes			
Name of former dentist:		City & state:	
Signature:		**Date:**	

NOTICE OF PRIVACY PACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health is important to us.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (10/13/03), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.

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Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (i.e. emails, voicemail, letters, texts, or calls).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in **writing** to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $2.00 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alterative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alterative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
***** You May Refuse to Sign This Acknowledgement *****

I_____, have received a copy of this office's Notice of Privacy Practices.
Name of Patient (or parent if under 18 years)

_____
Patient Name (printed) **Date**

_____
Signature of Patient (or parent if under 18 years) **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:

☐ Individual refused to sign	☐ Communication barriers prohibited obtaining the acknowledgement	☐ An emergency prevented us from obtaining acknowledgement	☐ Other (Please Specify):

GENERAL CONSENT

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate.

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In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

Subscriber Information

First and last name of Subscriber: _____
Member ID number or SSN of Subscriber: _____

Information Regarding Person Authorizing Releasing His/her Information

Name of person authorizing release: _____
Date of Birth person authorizing release: _____
Member ID or SSN of person authorizing release: _____

The following is an authorization allowing Royal Oak Family Dental to release information to whomever you designate. Royal Oak Family Dental is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that Royal Oak Family Dental may release my information to:

Address of person/organization that Royal Oak Family Dental may release information to:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing (and present my written revocation) to Royal Oak Family Dental. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand authorizing the use or disclosure of the information identified above is voluntary.

_____

Signature of individual authorizing the release of information **Date**

_____

If signing on behalf of another, please describe one's authority to act for the individual (power of attorney, legal guardian, etc.)