

**ALL SMILES DENTISTRY, P.C.**  
Welcome to the office of J.D. "Pete" Swan, D.D.S.

**\*\*\*\* Patient Information \*\*\*\***

Name \_\_\_\_\_ Prefers to be called \_\_\_\_\_  
                    First                      Middle                      Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_ Cell # or Pager # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Sex: Male / Female     Single     Married     Divorced     Separated     Widowed     Partnered

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ School if student \_\_\_\_\_

Patient employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Spouse Name \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

How did you hear about us? Yellow Book \_\_\_ Website \_\_\_ Family \_\_\_ Friend/Co-worker \_\_\_ Other \_\_\_

Person to contact in case of emergency \_\_\_\_\_ Contact #'s \_\_\_\_\_

**\*\*\*\* Responsible Party \*\*\*\***

Name of Person Responsible for this Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

**\*\*\*\* Primary Insurance Information \*\*\*\***

Policyholder \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Group \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN or ID \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Do You Have Additional Insurance?     Yes     No    If yes, please complete the following

**\*\*\*\* Secondary Insurance Information \*\*\*\***

Policyholder \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Group \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN or ID \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**OVER**

Former Dentist \_\_\_\_\_ Date of last cleaning \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Please check any of the following conditions that apply to you:

- Bad breath
- Grinding or clenching teeth
- Sensitivity to heat or cold
- Fluoridated water
- Bleeding gums
- Loose teeth or broken fillings
- Sensitivity to sweets
- Fluoride supplements
- Clicking/popping jaw/pain
- Periodontal treatment in past
- Sensitivity when biting
- Deep Cleaning
- Food collection between teeth
- Nervous about dental treatment
- Sores or growths inside mouth

If you could change anything about your smile, what would you change? \_\_\_\_\_

\*\*\*\* Medical History \*\*\*\*

Physician Name \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please list recent surgeries or hospitalizations \_\_\_\_\_

Current medications you take \_\_\_\_\_

Allergies: Penicillin Latex Aspirin Codeine Other \_\_\_\_\_

Excessive bleeding with procedures? Yes No Use tobacco products? Yes & how much \_\_\_\_\_ No

For Women: Are you pregnant? Yes No Possibly Nursing? Yes No Oral contraceptives? Yes No

Please check if you have had any of the following:

- Aids
- Eating Disorder \_\_\_\_\_
- Kidney Disease
- Anemia
- Emphysema
- Liver Disease
- Arthritis/Rheumatism
- Epilepsy
- Psychiatric Care
- Artificial Heart Valves
- Fainting/Dizzy Spells
- Radiation Treatment
- Angina Pectoris/Chest Pain
- Family History Cardiovascular Disease
- Respiratory Disease
- Artificial Joints/Hip/Knee
- Glaucoma
- Rheumatic Fever
- Asthma
- Headaches \_\_\_\_\_
- Recreational Drug Use
- Back Problems
- Heart Murmur
- Scarlet Fever
- Bleeding Abnormalities
- Heart Surgery \_\_\_\_\_
- Shortness of Breath
- Blood Disease
- Heart Pacemaker \_\_\_\_\_
- Sickle Cell Disease
- Cancer/ Tumors \_\_\_\_\_
- Heart Valve Prolapse
- Stroke
- Chemical Dependency
- Heart Failure
- Swelling of Feet/Ankles
- Chemotherapy
- Heart Disease /Attack \_\_\_\_\_
- Thyroid Disease
- Circulatory Problems
- Heart Bi-Pass /Stent \_\_\_\_\_
- Tuberculosis
- Congenital Heart Problems
- Hay Fever /Allergies /Hives
- Ulcer
- Cortisone Treatment
- Hemophilia
- Venereal Disease/other STD
- Cough, Persistent
- Hepatitis/Type \_\_\_\_\_ Year \_\_\_\_\_
- Alcohol Abuse
- Cough Up Blood
- Herpes / Cold sore/ Fever Blisters
- Other \_\_\_\_\_
- Diabetes
- High Blood Pressure
- Drug Addiction/Treatment
- HIV positive

\*\*\*\* Certification and Assignment of Dental Benefits \*\*\*\*

To the best of my knowledge, I certify that the previous information is complete and correct. 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 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 assign all dental benefits directly to Dr. Swan and I understand that I am financially responsible for all charges incurred whether or not paid and covered by insurance. I agree to pay for such services by either a major credit card, cash or Care Credit.

Signature of Responsible Party

Date

# ALL SMILES DENTISTRY, P.C.

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date \_\_\_\_\_

### SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person: Jimmy D. "Pete" Swan, D.D.S.

Telephone: 405-720-2828

Address: 5700 N.W. 135<sup>th</sup> Street, Oklahoma City, OK 73142

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

### SECTION C: SIGNATURE AND ACKNOWLEDGEMENT

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment, payment activities and health care operations only. I also acknowledge receipt of the Notice of Privacy Practices from All Smiles Dentistry, P.C.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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### FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communication barrier
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

(OVER)

# Notice of Privacy Practices Acknowledgement

*All Smiles Dentistry, P.C.  
Jimmy D. "Pete" Swan II, D.D.S.  
5700 N.W. 135<sup>th</sup> Street  
Oklahoma City, OK 73142*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received and read and do understand your Notice of Privacy Practices containing a more complete description of the uses of disclosures of my health information. I understand that this organization has the right to change its' Notice of Privacy Policy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT (IF CHILD): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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