Bobby J. Carmen D.D.S., F.A.G.D.

1141 Sonoma Park Drive, Norman, OK 73071
405-364-2200
www.drbobbycarmen.com

Patient Name: _____

Gender: ☐ Male ☐ Female Married

Patient's SS#: _____ Patient's DOB: _____

Address: _____

Email: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Employer: _____ Occupation: _____

Whom may we thank for referring you to our practice: _____

If patient is a minor or full-time student, please complete the following:

Mother's Name: _____

Mother's SS#: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Employer: _____ Occupation: _____

Father's Name: _____

Father's SS#: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Employer: _____ Occupation: _____

Billing Statements and any correspondence should be sent to:

_____

Please file the following dental insurance for benefits on my behalf:

Insurance Plan Name: _____

Insurance is offered through the following employer: _____

Subscriber's Name: _____

Subscriber's SS#: _____ Subscriber's DOB: _____

Patients are responsible for knowing and understanding the benefits and limitations of their insurance plan.

Emergency Contact: _____ Relationship: _____

Phone: _____

In the event that prescriptions are needed and must be called in, please provide the following information:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Authorization

I. **General Consent to Treatment**: I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by Dr. Carmen. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

II. **Release of Information**: I authorize agents of Dr. Bobby Carmen providing services on my behalf to release all billing and medical/dental information to other providers whom I may be referred to for follow-up care, the insurance company, employer or person acting on behalf of a preferred provider arrangemer or third party affiliated with the patient's care when such information is requested for payment, utilization review or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this office.

III. **Assignment of Insurance or Third Party Coverage**: I authorize any third party payor to pay directly to this office all benefits due and payable as a result of services rendered.

IV. **Acknowledgment of Responsibility to Pay for Services**: I understand that Dr. Carmen, as a courtesy, will file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason are not paid by any third party payor unless there is a specific written agreement between the doctor and the patient and the payor.

V. **Health Insurance Portability and Accountability Act**: We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respec to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (405) 364-2200.

VI. **Administrative Fees**: A $5.00 late fee will be added to statement each month when not paid by the due date. A $25.00 fee will be assessed for all missed appointments without prior notification. If it becomes necessary to enforce this guaranty by suit or by third party collectors, the undersigned agrees to pay Dr. Bobby Carmen the balance due plus any and all costs, attorney fees and reasonable expenses of collections.

Signature below is acknowledgement that you have received this notice and agree to the provisions therein.

Date: _____ Patient Signature: _____

Parent/Guardian Signature (if Minor Patient): _____

Bobby J. Carmen D.D.S., F.A.G.D.

1141 Sonoma Park Drive, Norman, OK 73071.
(405) 364-2200 www.drbobbycarmen.com

Date: _____

Reason for seeing the Doctor today: _____

Date of last Dental Visit: _____ Purpose of Visit: _____

Last Dental Cleaning: _____ Last full mouth x rays: _____

Previous Dentist's Name: _____ City, State: _____

How often do you visit the dentist: _____

How often do you brush/floss: _____

Check any and all that apply

☐ Hot or Cold Sensitivity
☐ Bad Mouth Odors/Bad Tastes
☐ Parents with Gum Disease/Tooth Loss
☐ Bite Lips or Cheeks Regularly
☐ Snore
☐ Difficulty Chewing
☐ Sensitivity to Sweets
☐ Frequent Cold Sores/Blisters
☐ Food Caught Between Teeth
☐ Mouth Breathe
☐ Gasp for Air While Sleeping
☐ Joint Pain
☐ Senstivity when Biting or Chewing
☐ Loose teeth/change in bite/ clench jaw/grind teeth
☐ Tired Jaws, especially in morning
☐ Click or Popping of Jaw
☐ Head, Neck, Shoulder Aches

Do you use tobacco products of any kind: ☐ Yes ☐ No How frequently: _____

Have you ever had any of the following:

☐ Orthodontic Treatment (braces)
☐ Serious Injury to Head/Mouth
☐ Oral Surgery (teeth extracted)
☐ BitePlate/Mouth Guard
☐ Periodontal Treatment
☐ Teeth Ground/ Bite Adjusted

Medical History

Have you been under the care of a medical doctor during the past two years for anything other than routine care: _____

Reasons: _____

Physician's Name: _____ Phone: _____

Have you been a patient in the hospital during the past five years: _____

Check any and all that apply at the present time, or have applied in the past:

☐ AIDS	☐ Allergies	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease	☐ Cancer
☐ Diabetes	☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Glaucoma	☐ Hay Fever	☐ Head Injuries
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disease
☐ Nervous Disorders	☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Venereal Disease	☐ Codeine Allergy	☐ Penicillin Allergy
☐ Latex Allergy	☐ Other		

_____

Please list any and all medications you are currently taking: _____

Are you aware of any allergic or adverse reaction to any medication or substance in the past:

_____

Do you have or have you had any disease, condition or problem not listed above?

_____

Women: Are you currently pregnant: ☐ Yes, Number of Months: _____ Are you Nursing: ☐ Yes

I understand the information on this form is necessary to provide me with dental care in a safe and efficient manner. I have provided the information to the best of my knowledge and if there is ever a change in my health, I will inform this office without fail at my next appointment.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Other Disclosure and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or and other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. Food and Drug Administration (FDA) We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/ Administrative Proceeding
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by a or with your written authorization and you may revoke the authorization as previously

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.