First Name: _____ Last Name: _____

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____

Home Phone: _____ Work Phone: _____ Ext.: _____

Sex: ☐ Male ☐ Female Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec.: _____

Email: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired CELL PHONE #: _____

Student Status: ☐ Full Time ☐ Part Time EMERGENCY CONTACT: _____

How did you hear about our office? ☐ Clipper ☐ Val Pac ☐ Patient ☐ Walk-In ☐ Other: _____

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Soc Sec.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

TO OUR PATIENTS WHO HAVE INSURANCE / CONSENT FOR TREATMENT

This office will cooperate with individuals who are covered by insurance. We ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided. You should look upon your insurance realistically as a device which helps in reimbursement for dental expenses. It is your company, and it is your responsibility to see that reimbursement is prompt. We will fulfill our obligation by completing all forms pertaining to your claim.

The fees we charge for services are usual and customary for this area. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different companies vary greatly in the types of coverage available. The ultimate responsibility of payment for services rendered is yours.

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

ARE YOU TAKING ANY MEDICATIONS, PILLS, OR DRUGS? ◯ Yes ◯ No **IF YES, PLEASE LIST:** _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No _____

Do you use controlled substances? ◯ Yes ◯ No _____

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Oak Creek Dental Care, LLC

132 E Drexel Ave, Oak Creek, WI 53154
(414)762-9010 • OakCreekDentalCare@sbcglobal.net

HIPAA Informed Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin law (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

Please read the following and complete the form as requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read the Privacy Practice Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, or the uses and disclosures we may make of your protected health care information, and/or other important matters about your protected health care information. A copy of our dental office's Notice of Privacy Practices is available upon request. We encourage you to read it carefully and completely before signing this consent.

SECTION A: The uses and disclosures being authorized.

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notices.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care.

☐YES ☐NO There are others I would like to have access to my records and information.
Please list the person(s) you would like involved in your care:

_____

☐YES ☐NO I give Oak Creek Dental Care consent to speak with and share information, including x-rays and medical records with healthcare providers involved with my treatment.

We may use professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information. Based on this professional judgement we may share/discuss information directly relevant to treatment option, costs and payment options with family members or friends who are involved in your care. (Statute 45CFR 164.51(b))

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Policy Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION B: Revocation.
Right to Revoke: This consent is effective until revoked by you. You may revoke consent at any time by giving written notice of revocation to this office. Revocation of consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you if you revoke this consent.

SECTION C: Individual Giving Consent.
I have had full opportunity to read and consider the contents of the consent. I understand that by signing this form I am confirming my written permission for disclosure of my protected health information as described in this form.

Patient Name (Printed): _____

Signature: _____ Date: _____

Please Select One: ☐Patient ☐Parent ☐Guardian

Oak Creek Dental Care, LLC
Office Information and Policies

Treatment Estimates and Consents:
We do our best to be transparent. When making an appointment, at the onset of treatment, or at the time of a consultation, we will provide you with a treatment proposal that includes any associated fees. Please keep in mind **this is only an estimate.** Although we make every attempt to anticipate all treatment that will be required and the associated cost, there are cases where the extent of a dental problem cannot be full understood until the treatment has begun. Unforeseen changes in treatment or clauses in your insurance can result in additional cost.

Payment Options:
Payment is due at the time of service, including any co-pays or coinsurances if you have dental insurance.
- We accept cash, personal checks, debit cards, Visa®, MasterCard®, Discover® and American Express®
- A $50 fee will be applied to any returned checks.
- Financing is available through CareCredit® with no interest if paid off within the promotional period for certain procedures.
- Any balances over 30 days are subject to a finance charge at a rate of 1.5% per month (18% annually). Should it become necessary to refer the account to an agency or attorney for collection, you will also be responsible for all costs associated with the collection efforts.

Dental Insurance:
Dental insurance is a helpful tool, but it does not cover treatment based on medical necessity. At times you may need treatment that is not covered by your insurance. Our top priority is your dental health and our treatment recommendations reflect that. Of course, we will always do our best to help you maximize your insurance benefits.

- **We are in network with: Delta Dental, Cigna Radius, Humana Dental, Aetna, Premier Dental Group, Anthem, Guardian, MetLife, United Healthcare, and United Healthcare Medicare.**
- If you have an HMO or DMO your plan may require you to go to specific providers to receive benefits.
- **We are not a Medicaid(Title 19) provider**. Patients with Medicaid are not eligible for benefits in our office and will be responsible for payment in full at the time of service.

Appointments:
We have reserved a time just for you when you make an appointment with us and we know your time is very important. We will do everything in our power to have you in and out on time. Likewise, we ask that you respect our time, and the time of other patients.
- **We require 48 hours notice** if you need to reschedule or cancel an appointment. Without this notice, we are unable to offer treatment to others patients that may have needed our care.
- **If you are late to your appointment**, we may not be able to accommodate you. Please call us if you know you will be late.

We may require a deposit or ask you to pre-pay for an appointment if:
- You have had cancelled appointments with no notice or insufficient notice
- You have had an outstanding balance
- The appointment length is over an hour or the service total is more than $1000

Patients under 18:
If your child is attending our office for the first time and is under the age of 18, a parent or legal guardian must accompany the child. All children under the age of 14 must always be accompanied by an adult to all appointments. Children over the age of 14 must have a signed consent on file to be seen without an adult present.

Initials: _____

OVER

Oak Creek Dental Care, LLC
Office Information and Policies

Treatment Consent:

I hereby authorize Dr. Ehsan Saleki and/or Dr. Lauren Hawkins and whomever the dentists designate as his/her assistant(s) to perform the procedure(s) listed on my proposed treatment plan.

In the event an unforeseen condition arises in the course of these designated procedures, I request and authorize the doctor to do whatever further treatment he/she deems advisable.

I am informed fully and understand that there are certain unavoidable complications inherent in any type of dental procedures. These may include but are not limited to: post-operative bleeding, swelling, bruising, stiff jaw, loss of or loosened restorations, pain, infection, temporary or permanent numbness or tingling of the lower lip, tongue, chin, gums, cheek or teeth. Less common complications can include but are not limited to: temporal-mandibular joint problems, sinus exposure, and swallowing or aspiration of teeth or restorations. After periodontal surgery, teeth may appear longer or become sensitive to hot and cold.

I consent to the administration of local anesthesia, antibiotics, analgesic (nitrous oxide) or any other drug that may be deemed necessary in my case. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes but is not limited to: adverse drug response (e.g. allergic reaction and it's manifestations). If antibiotics are prescribed, I understand that an antibiotic may have an adverse reaction to oral contraceptives, in which case the contraceptive may become ineffective.

I realize it is mandatory that I give a complete and accurate medical and personal history. I also understand that all drugs taken legally or illegally must be reported to the doctor. If unreported, a reaction could result in possible death. I agree to follow all instructions as directed. I realize that in spite of the possible complication, my procedure is necessary and desired by me. A full explanation of all complications of the procedures and anesthesia is available to me upon request from the doctor.

Patient Name (Printed): _____

Responsible Party Name (Printed): _____

Signature: _____ Date: _____

Circle One: Patient/Parent/Guardian

DENTAL HISTORY FOR : _____

HOW LONG AGO WAS YOUR LAST CLEANING?		
HOW LONG AGO WERE YOUR LAST FULL MOUTH X-RAYS TAKEN?		
HOW OFTEN DO YOU HAVE DENTAL EXAMS?		
HOW OFTEN DO YOU BRUSH?		
HOW OFTEN DO YOU FLOSS?		
PLEASE CIRCLE YES OR NO FOR ALL OF THE FOLLOWING:		
DO YOU SMOKE OR CHEW TOBACCO?	YES	NO
ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	YES	NO
ARE YOUR TEETH SENSITIVE TO SWEETS?	YES	NO
ARE YOUR TEETH SENSITIVE TO BITING OR CHEWING?	YES	NO
DO YOU HAVE MOUTH ODORS OR BAD TASTES?	YES	NO
DO YOU OFTEN GET COLD SORES, BLISTERS OR OTHER ORAL LESIONS?	YES	NO
DO YOUR GUMS BLEED OR HURT?	YES	NO
HAVE YOU NOTICED ANY LOOSE TEETH?	YES	NO
HAVE YOU NOTICED A CHANGE IN YOUR BITE?	YES	NO
DOES FOOD OFTEN GET CAUGHT BETWEEN YOUR TEETH?	YES	NO
IF YES, WHERE:		
DO YOU CLENCH OR GRIND YOUR TEETH?	YES	NO
ARE YOU OFTEN TIRED, FATIGUED OR SLEEPY DURING THE DAY?	YES	NO
HAVE YOU BEEN TOLD THAT YOU SNORE?	YES	NO
HAVE YOU BEEN DIAGNOSED WITH OBSTRUCTIVE SLEEP APNEA (OSA)?	YES	NO
HAVE YOU IN THE PAST OR ARE YOU CURRENTLY USING A CPAP?	YES	NO
HAVE YOU HAD ORTHODONTIC TREATMENT (BRACES)?	YES	NO
HAVE YOU EVER HAD ORAL SURGERY?	YES	NO
HAVE YOU EVER HAD PERIODONTAL (GUM) SURGERY OR TREATMENT?	YES	NO
HAS YOUR BITE EVER BEEN ADJUSTED?	YES	NO
DO YOU OR HAVE YOU EVER HAD A MOUTH GUARD?	YES	NO
HAVE YOU EVER HAD A SERIOUS INJURY TO THE MOUTH OR HEAD?	YES	NO
IF YES, PLEASE DESCRIBE:		
ARE YOU PLEASED WITH THE APPEARANCE OF YOUR SMILE?	YES	NO
ARE YOU HAPPY WITH THE COLOR OF YOUR TEETH?	YES	NO
ARE YOU HAPPY WITH THE SHAPE OF YOUR TEETH?	YES	NO
ARE THERE SPACES BETWEEN YOUR TEETH THAT YOU DO NOT LIKE?	YES	NO
DO YOU HAVE OLD FILLINGS OR RESTORATIONS YOU AREN'T HAPPY WITH?	YES	NO
DO YOU LIKE THE WAY YOUR TEETH FIT TOGETHER WHEN YOU BITE?	YES	NO
DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT?	YES	NO
HAVE YOU EVER HAD AN UPSETTING DENTAL EXPERIENCE?	YES	NO
IF YES, PLEASE DESCRIBE:		