TIME 01:17 PM DATE 3/26/2021

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

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

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 1:22 PM

Callie Bouziden, DDS, PPLC.

Date 3/26/2021

Eaglesoft Medical History Current Form

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you have medial marijuana card?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X _____ Date: _____

Mustang Family Dental

1444 N Mustang Rd
Mustang, OK 73099
405-376-3320
Callie D. Bouziden, DDS, P PLLC

Smile Questionnaire

- Are you satisfied with the appearance of your teeth? _____yes _____no
  If no, why?
  _____
  _____
- Would you like your teeth to be whiter? _____yes _____no
- Would you like your teeth to be straighter? _____yes _____no
- Do you have spaces in your teeth that you would like closed? _____yes _____no
  If yes, where: _____
- Do you have missing teeth that you would like to replace? _____yes _____no
  If yes, where: _____
- Do you have old silver fillings that you would like to replace with tooth-colored fillings?
  _____yes _____no
- What is your top priority concerning your teeth?
  _____
  _____
  _____

Esthetic Self-Assessment

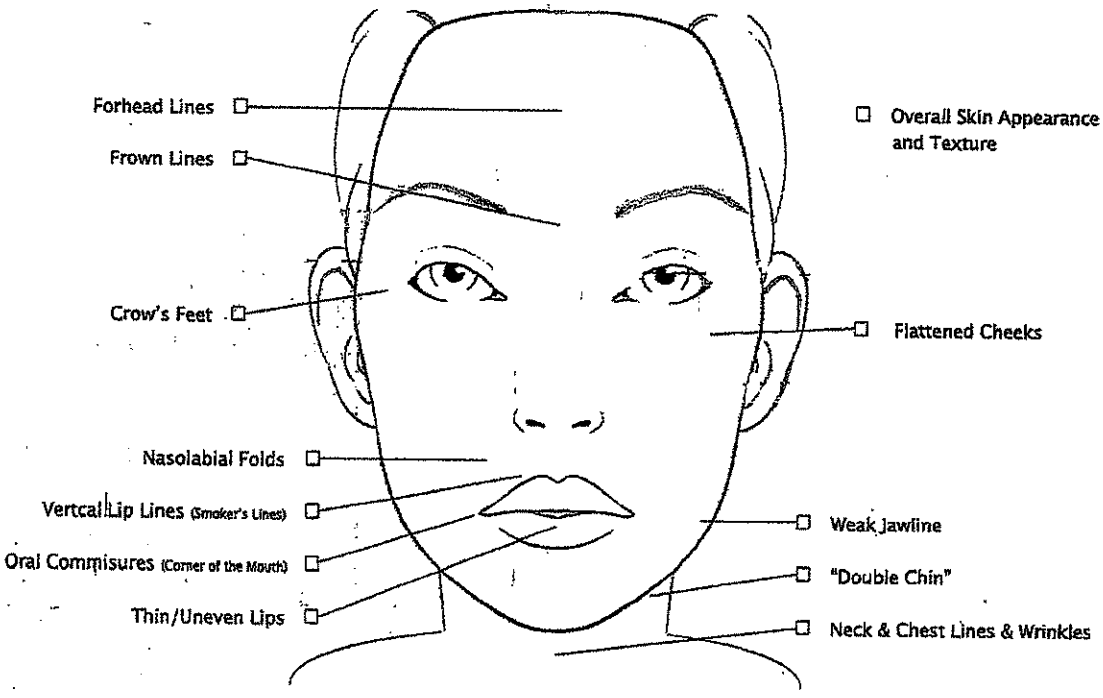
Name:_____ **Date:**_____

Other than the services we have already provided for you, what additional services would like to Learn about? Please check all that apply.

☐ Facial injectable/fillers	☐ Drooping brow	☐ Hips
☐ Facial Fine lines/wrinkles	☐ Drooping eyelids	☐ Legs
☐ Thin lips	☐ Facial fullness/drooping	☐ Facial contouring
☐ Blotchy skin	☐ Neck wrinkles	☐ Body contouring
☐ Facial Veins	☐ Permanent Makeup	☐ Acne scarring
☐ Facial Redness	☐ Scar Revision	☐ Acne control
☐ Brown spots/age spots/freckles	☐ Abdominal area	☐ Loose skin above knees/elbows
	☐ Crows feet	☐ Stretchmarks

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your esthetic goals and select the best treatment for you.



Your Top 3 Areas of Concern:

1.
2.
3.

Your Treatment Plan Timeline (FOR OFFICE USE ONLY)

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Callie D. Bouziden, DDS, P PLLC

Mustang Family Dental

DENTAL WARRANTY

People are always asking us how long a crown or a bridge should last. In our office we strive for perfection and satisfaction, which is why we are happy to provide you with this warranty that as far as we know, is unique to the dental profession.

If a crown or bridge becomes defective within a 5 year period due to breakage or misfit, we will be happy to repair or replace it. This does not include situations like accidents (like an auto wreck), that would break a regular tooth also. See schedule of benefits below:

First year of service (from time of placement) – 100% coverage
Second year of service – 70% of coverage
Third year of service – 60% of coverage
Fourth year of service – 50% of coverage
Fifth year of service – 40% of coverage
Sixth year of service – 0% of coverage
Composite Fillings or Bonding and Dental Sealants – 2 years

In order to encourage you to protect your investments in your teeth, this policy is **Null and Void if you do not maintain your 3-6 month continuing care, cleaning, annual x-rays and annual exam.** It's your responsibility to make these visits. However, by maintaining your dental health on a routine basis it is quite probable that your investment in your teeth will last well beyond the 5 years!

Prevention is the key. Crown and bridges are designed to protect and hold teeth together: they restore the proper form and function to a tooth and area, and can do it for a very long time. Crown and bridges prevent future tooth problems. Regular home care with a brush, floss, and any other recommended device is **preventive** action. Having your teeth professionally checked and cleaned, and having x-rays taken, can **prevent** most dental disease. This is why our replacement policy will be **null and void** if we don't see you for your regular 3-6 month check-ups. With this action on our part, your teeth and gums will be healthier for it. You and your teeth are winner.

Signature X_____ Date_____

Cancellation Policy

Restorative and Hygiene Appointments

We ask for at least 24 Hours advance notice for canceling or rescheduling an appointment; otherwise a $50 fee *may* be added to your account and will have to be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people: the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

Signature/Date X

Acknowledgment and Release

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit claims and/or reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. We will do what we can to verify your dental benefits, however each patient's insurance plan is unique and it is ultimately ***your responsibility*** to know what *your* benefits are.

Collections

We collect your *estimated co-pay* at the time of service. In the event a balance becomes more than 60days over-due, billing may be turned over to an outside collection agency. The responsible party on your account agrees to pay interest, collection and or other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature/Date X

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Consent for Use and Disclosure of Health Information

Patient Giving Consent: X _____ Date: _____

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 healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices containing the changes.

If you have someone you would like us to share your protected health information with please list them below:

Name: _____ Cell: _____

Relationship to patient: _____

Right to Revoke: You will have the right to revoke your own consent or this consent for the person(s) listed above at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation. We may decline to treat you if you do revoke your own consent.

SIGNATURE: X _____ DATE: _____