WESTMOORE DENTAL STUDIO

DATE _____ / _____ / _____

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	PREFERRED NAME	
HOME ADDRESS		CITY	ST	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL	OK TO TEXT Y / N OK TO EMAIL Y / N
D O B	SEX (CIRCLE) M / F	SSN	DRIVERS LICENSE / ID #	DL / ID Expiration
EMPLOYER	EMPLOYER ADDRESS / CITY / ST / ZIP		EMPLOYER PHONE	
HOW DID YOU HEAR ABOUT OUR OFFICE				

RESPONSIBLE PARTY IF SAME AS ABOVE, CHECK HERE ☐ & SKIP TO NEXT SECTION

FIRST NAME	MI	LAST NAME	DOB	SEX (CIRCLE) M / F	RELATION TO PATIENT
SSN	DRIVERS LICENSE / ID #	HOME PHONE	CELL PHONE		
EMPLOYER	EMPLOYER PHONE	POSITION			
EMPLOYER ADDRESS	CITY	ST	ZIP		

MEDICAL CONTACTS

PREFERRED PHARMACY	PHARMACY LOCATION	PHARMACY PHONE
CURRENT PRIMARY CARE PHYSICIAN	DR. NAME	DR. PHONE

EMERGENCY CONTACT

FIRST NAME	LAST NAME	RELATION TO PATIENT
HOME PHONE	WORK PHONE	CELL PHONE

PRIMARY DENTAL INSURANCE IF NO DENTAL INSURANCE, TELL ME ABOUT THE IN-HOUSE DISCOUNT PLAN: ☐ YES ☐ NO

INSURED FIRST NAME / LAST NAME	DOB	SSN	EMPLOYER
PRI INS CO. NAME	INS PHONE	POLICY #	GROUP #

SECONDARY DENTAL INSURANCE

INSURED FIRST NAME / LAST NAME	DOB	SSN	EMPLOYER
PRI INS CO. NAME	INS PHONE	POLICY #	GROUP #

MEDICAL INSURANCE SOME PROCEDURES ARE BILLABLE TO MEDICAL, PLEASE PROVIDE:

INSURED FIRST NAME / LAST NAME	DOB	SSN	EMPLOYER
I INS CO. NAME	INS PHONE	POLICY #	GROUP #

WESTMOORE DENTAL STUDIO

DATE _____ / _____ / _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? Y / N	PHYSICIAN NAME:	PHYSICIAN PHONE:	DATE OF LAST MEDICAL EXAM:

WOULD YOU CONSIDER YOURSELF TO BE IN: POOR / FAIR / GOOD / EXCELLENT HEALTH (circle one)

IN PAST 12 MONTHS, HAS THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH? Y / N

EXPLAIN IF YES:

DO YOU HAVE A COUGH, SORE THROAT OR FEVER? Y / N	DO YOU USE TOBACCO (INCLUDING VAPE)? Y / N	DO YOU USE CONTROLLED SUBSTANCES? Y / N	DO YOU REQUIRE A PRE-MED FOR DENTAL APPOINTMENTS? Y / N

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATION CONTAINING BISPHOSPHONATES? Y / N
IF SO, WHEN WAS YOUR LAST TREATMENT?

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING, INCLUDING NON-PRESCRIPTION AND HERBAL SUPPLEMENTS?

DO YOU SNORE OR BEEN TOLD THAT YOU SNORE? Y / N	HAVE YOU HAD A SLEEP STUDY OR TOLD TO GET ONE? Y / N	DO YOU WEAR A C-PAP OR BEEN TOLD TO? Y / N	HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? Y / N

INDICATE IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

□ ANESTHETIC (LOCAL) □ ASPIRIN □ CODEINE
□ LATEX □ METAL □ PENICILLIN
□ SULPHA □ OTHER:_____

WOMEN, PLEASE INDICATE IF YOU ARE:

□ PREGNANT IF SO, HOW MANY WEEKS _____

□ TAKING ORAL CONTRACEPTIVES □ NURSING

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

□ACID REFLUX	□CHEST PAIN	□HERPES	□PSYCHIATRIC CARE	□TUBERCULOSIS
□ALCOHOL/DRUG ABUSE	□DIABETES	□HIGH CHOLESTEROL	□RADIATION TREATMENT	□TUMOR / GROWTH
□ALLERGIES (SEASONAL)	□DIZZINESS / FAINTING	□HIV/AIDS	□RESPIRATORY ISSUES	□ULCER
□ALZHEIMERS	□EMPHYSEMA	□HYPERTENSION (HBP)	□RHEUMATIC FEVER	□WHEELCHAIR ASSISTANCE
□ANEMIA	□CARRY EPINEPHRINE	□HYPOTENSION (LBP)	□RHEUMATISM	
□ANGINA	□EPILEPSY	□HYPOGLYCEMIA	□SEIZURES	
□ART. HEART VALVE	□EXCESSIVE BLEEDING	□INSOMNIA	□SHINGLES	
□ARTHRITIS/GOUT	□FIBROMYALGIA	□IRREGULAR HEART RATE	□SINUS PROBLEMS	
□ARTIFICIAL JOINTS	□FREQUENT HEADACHES	□KIDNEY DISEASE	□SLEEP APNEA	
□ASTHMA	□GLAUCOMA	□LIVER DISEASE	□STOMACH PROBLEMS	
□ATRIAL FIBRILATION	□HEART ATTACK	□MITRO VALVE PROLAPSE	□STROKE	
□BLOOD DISEASE	□HEART DISEASE	□NERVOUS DISORDER	□SWELLING LIMBS	
□BLOOD THINNER	□HEART MURMUR	□OSTEOPOROSIS	□THYROID DISEASE	
□CANCER	□HEMOPHILIA	□PACEMAKER	□TONSILITIS	
□CHEMO / RADIATION	□HEPATITIS	□PAIN IN JAW / TMJ	□TROUBLE SLEEPING	

NAME OF PREVIOUS DENTIST:_____ DATE OF LAST EXAM: _____

WHAT IS THE MAIN REASON FOR YOUR DENTAL VISIT TODAY?_____

ON A SCALE OF 1 (Poor) TO 10 (Excellent) HOW WOULD YOU RANK YOUR DENTAL HEALTH?_____

HOW FREQUENTLY DO YOU BRUSH YOUR TEETH? _____ HOW FREQUENTLY DO YOU FLOSS YOUR TEETH? _____

DO YOU LIKE YOUR SMILE?_____IF NO, WHAT WOULD YOU CHANGE?_____

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

BLEEDING WHILE BRUSHING OR FLOSSING?	□ Y □ N	JAW CLICKING, PAIN?	□ Y □ N
SENSITIVITY TO HOT OR COLD LIQUIDS/FOOD?	□ Y □ N	DIFFICULTY OPENING, CLOSING, CHEWING?	□ Y □ N
SENSITIVITY TO SWEET OR SOUR LIQUIDS/FOOD?	□ Y □ N	GUM PROBLEMS?	□ Y □ N
TOOTH PAIN?	□ Y □ N	DRY MOUTH?	□ Y □ N
SORES OR LUMPS IN OR NEAR MOUTH?	□ Y □ N	REMOVABLE PARTIALS?	□ Y □ N
FREQUENT LIP OR CHEEK BITING?	□ Y □ N	DENTURES?	□ Y □ N
FREQUENT HEADACHES?	□ Y □ N	DIFFICULT EXTRACTION?	□ Y □ N
HEAD, NECK, OR JAW INJURY?	□ Y □ N	ORTHODONTIC TREATMENT (BRACES)?	□ Y □ N
CLENCHING OR GRINDING?	□ Y □ N	HOME ORAL HYGIENE INSTRUCTIONS	□ Y □ N

WESTMOORE DENTAL STUDIO

DATE _____ / _____ / _____

ACKNOWLEDGEMENT OF OFFICE POLICIES

Patient Name:_____

_____ *Initial*

FINANCIAL RESPONSIBILITY: I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due at the time services are rendered unless financial arrangements have been made. I understand any debt not paid within 90 days will be sent to collections and I will be responsible for all collections and legal fees related to that debt. I understand I am responsible for all charges for services whether or not paid by insurance. I authorize Westmoore Dental Studio ("the office") to disclose all information necessary to verify my dental and medical insurance eligibility.

_____ *Initial*

ASSIGNMENT OF BENEFITS: I hereby assign all dental and medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Westmoore Dental Studio. I understand that any payment made directly to me by my dental and/or medical carrier will be immediately transferred to the office.

_____ *Initial*

PRIOR EXPRESS CONSENT FOR CALLS/TEXTS/EMAILS: By providing the number of my land line or cell phone and my email address now or in the future, I expressly consent and agree that the office may call me using an automated system or otherwise, leave me a voice message, send me a text, and/or send me an email related to dental appointments and/or account. I agree that Westmoore Dental Studio may monitor and record any telephone calls to assure the quality of its service or for other reasons. I can opt out of emails and texts at any time by contacting the office.

Home:_____ **Cell:**_____

Email:_____

_____ *Initial*

PHOTOGRAPHY / VIDEO IMAGES: Westmoore Dental Studio will be using electronic medical records, including your photograph, to maintain your health care information. The office may also authorize the use and disclosure of my name, photograph/video images and/or testimonials for marketing purposes by Westmoore Dental Studio. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. I may withdraw this consent by submitting a written notice to Westmoore Dental Studio. We will never sell your information to a third party.

_____**YES** - I agree to have my photo taken and stored in the office's electronic medical system.

_____**YES** - I agree to have my photos/videos/testimonials used for social media and/or advertising efforts.

_____**NO** – I do not wish to have my photo/video/testimonial used for social media and/or advertising efforts.

I have read and understand Westmoore Dental Studio's Office Policies.

Patient Signature:_____

Or

Responsible Party Signature:_____ **Relation to Patient:**_____

WESTMOORE DENTAL STUDIO

DATE _____ / _____ / _____

ACKNOWLEDGEMENT OF APPOINTMENT POLICY

Patient Name:_____

Our goal at Westmoore Dental Studio is to provide quality dental care in a timely manner. We do understand issues arise that could prevent you from making your appointment. We are asking patients to provide us with a notice of **48 business hours** if an appointment cannot be kept. This allows us time to fill our schedule with patients that may be on a waiting list. We appreciate your understanding and consideration regarding our office appointment policy:

- **Cancellation or rescheduling of an appointment prior to 48 business hours of the appointment will result in NO CHARGE.**
- **A failed appointment is an appointment that is cancelled or rescheduled without a 48 business hour notice OR an appointment where the patient does not show up.**
- **We allow for one (1) courtesy appointment change with a 24 business hour notice.**
- **Any additional failed appointments will be charged a fee of $50 for a hygiene appointment and/or $100 *per scheduled hour* for a doctor's appointment.**
- **After two (2) failed appointments, we may require a deposit of up to 100% that will be applied to your appointment in order to reserve any future appointments.**
- **After three (3) failed appointments, you could be dismissed from the practice.**
- **Late arrivals after ten (10) minutes may have to be rescheduled.**
- **Appointments requiring more than 2 hours will require $100 deposit and will be discussed and collected up front at the time of treatment scheduling.**
- **Our office can be notified of confirmations, cancellations, or reschedule requests 24/7 via phone (voicemail), text, or email. If the office is closed, you can still communicate with us and we will contact you the next business day.**

I have read and understand Westmoore Dental Studio's Appointment Policy.

Patient Signature:_____

Or

Responsible Party Signature:_____ **Relation to Patient:**_____

WESTMOORE DENTAL STUDIO

DATE _____ / _____ / _____

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by / to anyone outside of our practice. You may gain access to this information if you desire. Please review it carefully. The privacy of your health information 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 on April 14, 2003 and will remain in effect.

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 or 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/disclose your health information to a physician or other healthcare provider who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

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**

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member picking up records, referral to dental specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give 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.

- **Persons Involved in Care**

We may use or disclose health information to notify, or assist in the notification of (included 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 or your health information, we will provide you with an opportunity to object to such uses of 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 that 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-Relation Services: Our dental office does not use patient information for any marketing purposes. 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 it is required by law to do so (i.e. missing person, etc.)

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.

WESTMOORE DENTAL STUDIO

DATE _____ / _____ / _____

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to lawfully authorize federal official's health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Email / Texting: We may use or disclose your health information to provide you with appointment reminders or treatment plan information (such as voicemail messages, texts, emails or letters). You may opt out of emails and texting at any time by contacting the office.

- **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 may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. 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 any purpose, 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 alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, 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. It must explain why the information should be amended. We may deny your request under certain circumstances.

- **Questions and Complaints**:

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that 1) we may have violated your privacy right, 2) you disagree with a decision we made about access to your health information, 3) in response to a request you made to amend or restrict the use or disclosure of your health information or 4) to have us communicate with you by alternative 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.

Contact Officer: **Dr. Jeffrey Scammahorn, Owner**

Telephone: **405-692-5800**

Address: **11521 S. Western, Suite C**

Oklahoma City, Oklahoma 73170

WESTMOORE DENTAL STUDIO

DATE _____ / _____ / _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name (Print): _____

I have been offered and/or received a copy of Westmoore Dental Studio's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

I understand that I may request a copy of the privacy policies at any time.

I may refuse to sign this acknowledgement.

Expiration –

3 Years from Initial Signature and/or Insurance Change and/or when Patient Reaches Age of 18

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION: (ie. Spouse, Adult Children, Parent, Nearest Relative, Emergency Contact):

Name / Relationship / Phone

_____ /_____ / _____

_____ /_____ / _____

_____ /_____ / _____

Signature: _____

☐ **Patient** ☐ **Parent** ☐ **Guardian/Other**_____