WEST EDMOND'S FAMILY DENTIST

Dr. Donald G. Ashburn, Jr.

340 S. Santa Fe Ave. | Edmond OK 73003 | DonAshburnDDS.com

WELCOME! *The benefits of a happy, healthy smile are immeasurable! Our goal is to help you maximize your dental health. Filling out this form completely will assist us in caring for you.*

ABOUT THE PATIENT

Today's Date: _____/_____/______

Patient Name: ____ I prefer to be called: _______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: ___________________

Social Security #: ____________________ DL #:________________ Birth Date: _____/_____/_____ Age:______

Phone # Home: ______________ Work: _______________ Cell:______________ Best time to call: ___________

Address:____ Email:_____________________________
Street City State Zip Code

Full time student? ☐ Yes ☐ No School: ________________________________ Location: __________________
City State

MEDICAL and DENTAL HISTORY

Reason for today's visit: ____

Have you ever had any of the following? [Check all that apply] How often daily do you brush?_____ floss?_____

Allergies (Please List):
☐ Latex ☐ Metals
☐ ________________
☐ ________________
☐ ________________
☐ Anemia
☐ Arthritis
☐ Artificial Joints / Valves
☐ Asthma
☐ Cancer / Chemotherapy
☐ Diabetes: Type I or II
☐ Drug / Alcohol Abuse
☐ Epilepsy / Seizures
☐ Excessive Bleeding

☐ Emphysema / Glaucoma
☐ Fever Blisters / Herpes
☐ Gum / Perio Disease
☐ Heart Attack / Stroke
☐ Heart Murmur
☐ Hepatitis (any type)
☐ High Blood Pressure
☐ HIV+ / AIDS
☐ Hospitalized for Any Reason: ______________
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker

☐ Pregnancy Due date:____________
☐ Psychiatric Problems
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Severe Headaches
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Problems
☐ TMJ / Jaw Pain
☐ Tuberculosis (TB)
☐ Ulcers / Colitis
☐ Venereal Disease

List All Drug Allergies:
☐ Penicillin
☐ ________________
☐ ________________
☐ ________________
☐ ________________

List Current Medications:
☐ ________________
☐ ________________
☐ ________________
☐ ________________
☐ ________________
☐ ________________

- Previous Dentist and Location: ____ Last Visit: ____/_____/______
City State
- Have you ever had any complications **during or following** dental treatment? ☐ Yes ☐ No
If yes, please explain:____
- Have you been told you **need to take an antibiotic before having any dental treatment?** ☐ Yes ☐ No
If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:____
- Name of Physician: ____ Phone:_____________________
- Do you have **any** health or dental problems, **past or present**, that need further clarification? ☐ Yes ☐ No
If yes, please explain:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. **If I ever have any change in my health, I will inform the doctor before or at the next appointment without fail or delay.**

____ Date: ______/_____/_______
Signature of patient, parent or guardian

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet/Website ☐ Insurance Provider ☐ Relative ☐ Friend ☐ Office/Co-worker ☐ Phone Book

☐ Advertising ☐ Other: ____________ Name of person or organization: ______________________________

SPOUSE or RESPONSIBLE PARTY

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other:__________________

Social Security #: ______________________ DL #:____________________ Birth Date: _____/_____/______

Phone # Home: ______________ Work: _____________ Cell:____________ Best time to call: ___________

Address: ____
Street City State Zip Code

EMPLOYMENT

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _________________________________ Occupation: __________________________

Address: ____
Street City State Zip Code

DENTAL INSURANCE

Primary

Name of Insured: ______________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____/_____/_____ Social Security #: __________________ Group #: _______________

Insured's Address:____
Street City State Zip Code

Insured's Employer Name: ____________________________________ Phone: (____)______________

Insurance Plan Name:_______________________________________ Phone: (____)______________

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________

Secondary

Name of Insured: ______________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____/_____/_____ Social Security #: __________________ Group #: _______________

Insured's Address:____
Street City State Zip Code

Insured's Employer Name: ____________________________________ Phone: (____)______________

Insurance Plan Name:_______________________________________ Phone: (____)______________

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________

Financial Consent for Services

As a part of your treatment, financial arrangements are made in advance as an effort to eliminate misunderstandings. The practice depends upon reimbursement from patients for the costs incurred in their care. A patient's financial responsibility needs to be understood before treatment begins.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or by credit card at the time services are performed. **When insurance coverage is to be filed, the patient portion or copayment is due at the time services are rendered.**

Patients who carry dental insurance need to understand that all dental services furnished are charged directly to the patient - not the insurance company. **The patient is personally responsible for payment of all dental services rendered regardless of nonpayment or denial of coverage by an insurance company.** This dental office cannot render services on the assumption that charges will be paid by an insurance company in a timely manner. Should an insurance company delay payment for a claim beyond 60 days the total amount billed will be due from the patient. Ultimately the agreement for dental insurance benefits is between the patient and the insurance company - not the dental practice and the insurance provider.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. A re-billing fee may also be charged to accounts having balances not paid on or before the following billing cycle date.

I understand that a fee estimate listed for my dental care can only be extended for a period of three (3) months from the patient examination date.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services at the time said services are rendered, or by the billing due date if credit shall be extended and assign all applicable insurance benefits and payments to said Doctor, or his assignee. I further agree that the value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. **I have read the above conditions of treatment and finances and agree to their content.**

______________________________________ Date: _____/_____/_____ Relationship to Patient: _______________
Signature of patient, parent or guardian

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