First Name: _____ Last Name: _____

Preferred Name: _____ Birth Date:_____

Responsible Party Information:

First Name: _____ Last Name:_____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____Cell Phone:_____

Birth Date: _____S.S.N. _____

E-Mail:_____

How would you like to be contacted for appointment reminders?

(Please mark one)

Text Message on: _____ Y/N

Email on : _____ Y/N

Employer :_____

Name of insured: _____

D.O.B (if different from above): _____

S.S.N. (if different from above): _____

Relationship to insured:_____

Employer: _____

Insurance Co.: _____

Acknowledgement of Receipt of

Notice of Privacy Practices

(You May Refuse to Sign this Acknowledgement)

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please Print Name)

_____ _____

(Signature) (Date)

TULSA PrecisionDental

INFORMED CONSENT GENERAL CONSENT FOR TREATMENT

I understand that I have the following conditions requiring dental treatment in the opinion of my dentist:

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions, side effects to reactions to anesthetic that are possibly life threatening and necessitate emergency care
- A blood filled swelling called a hematoma, that can form when a needle, used during an injection, hits a blood vessel
- During a “filling” preparation , the effects of decay and the removal of the decay may cause a nerve in the middle of the tooth to be exposed or damaged. This may require the tooth to have root canal therapy and asubsequent crown or full coverage restoration. In severe cases, tooth extraction may be required
- Fractures of restorations or recurrent decay may occur after placement. This may be corrected with a new filling or require a crown
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that may require additional treatment
- Delayed healing of an extraction site(dry socket) necessitating additional care
- Sinus involvement during removal upper molars which may require additional treatment or surgical repair at a later date
- Remainder of a root tip that may necessitate additional care or referral to a specialist
- Involvement of the nerves during the removal of teeth, anesthetic administration, tooth preparation resulting in the temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, pain and/or restricted jaw opening that may persist for several days or longer
- Failure of the dental procedure necessitating additional treatment, retreatment or extraction
- Breakage of dental instruments or perforation inside the dental canal making additional treatment necessary, referral to a specialist, or loss of tooth
- Complications during treatment including fracture or dislocation of jaw necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered guarantees.

Patient Name _____Date_____

Patient/Guardian Signature_____Date_____

Financial Guidelines

We are committed to providing you with the best possible dental care. It is our goal that you understand your treatment needs, as well as your financial responsibility before treatment begins. We strive to accurately predict the cost of your dental care and work with your budget. If you have insurance, we want to help you receive your maximum allowance benefit. To provide you the best possible experience, we ask for your assistance.

- We will file the necessary paperwork to bill your insurance company for your dental treatment. We ask that you please provide us with accurate information at the time of your appointment.
- We request payment in full at the time of service, if you do not have insurance coverage unless other financial arrangements have been made in advance.
- We ask that the parent bringing a child to the practice be prepared with co-payment or full payment at the time of treatment regardless of custody agreements.
- We ask that you pay by **cash, credit card or debit card** for all estimated co-payments at the time of treatment. We are happy to help you secure financing from our available options.
- In cases where payments have been approved, we will use a Debit/Credit Card authorization form to gather information and get signed permission.

Agreement of Financial Guidelines

I request and authorize Drs Chris and Kristie Vinson to provide me with dental care. I understand that I am personally responsible for the charges for services I receive.

I agree to make full payment for services I receive. I understand that regardless of dental insurance benefits, any treatment I receive is my financial responsibility.

I hereby authorize Drs Chris and Kristie Vinson at their discretion, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services.

I also authorize my insurance carrier to make payment directly to Drs Chris and Kristie Vinson.

Your signature below will acknowledge that you have read and agree to our financial guidelines.

Signature _____ Date _____

Time 12:42 PM | Tulsa Precision Dental | Date 5/14/2019

Eaglesoft Medical History

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 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	Tonsillitis ◯ 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:_____

TULSA PRECISION DENTAL
CHRISTOPHER C VINSON DDS
KRISTIE VINSON DDS

7104 South Sheridan, Suite 8
Tulsa, Oklahoma 74133
918-492-1917

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Dr Vinson'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.

Expiration -- 3 Years from Initial Signature; Insurance Change; Patient reaches age of 18

I consent for the office of Tulsa Precision Dental to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ /_____ / _____

_____ /_____ / _____

Signature: _____

□ Patient □ Parent □ Guardian / Other