Welcome to Oak Park Dental

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name _____ Date_____ SS#_____
First Middle Initial Last
Address_____ City_____ State_____ Zip_____
Female Male Birthdate_____ Email_____
Home Phone (_____) _____ Cell Phone (_____)_____ Work Phone (_____)_____
Do you prefer to receive calls at Home Work Cell No Preference
Married Widowed Single Seperated Divorced

Patient Employer/School _____ Occupation_____
Employer/School Address _____ City_____ St_____Zip_____
Spouse or parent's name _____ Employer_____ Work Phone(___)_____
Whom may we thank for referring you to us_____
Person to contact in case of emergency_____ Phone(_____)_____

Responsible Party

Name of person responsible for this account_____
Relationship to patient_____ Phone(_____)_____
Address_____ City_____ State_____ Zip_____
Name of employer_____ Work Phone(___)_____

Insurance Information

Name of Insured_____ Relationship to Patient_____
Birthdate_____ Social Security #_____ Date Employed_____
Name of employer_____ Work Phone(___)_____
Insurance Co._____ Group#_____ Employer#_____
Insurance Co. Address_____ City, State, Zip _____
How much is your deductible?_____ How much have you used?_____ Max Benefit?_____

DO YOU HAVE ADDITIONAL INSURANCE Yes No IF YES PLEASE COMPLETE THE FOLLOWING:
Name of Insured_____ Relationship to Patient_____
Birthdate_____ Social Security #_____ Date Employed_____
Name of employer_____ Work Phone(___)_____
Insurance Co._____ Group#_____ Employer#_____
Insurance Co. Address_____ City, State, Zip _____
How much is your deductible?_____ How much have you used?_____ Max Benefit?_____

*****Payment is due at time of service. The estimate we give you is an estimate only, any portion the insurance does not pay is your responsibility. I understand and agree with the above statement..***

Signature & Date:_____

MEDICAL HISTORY
For Patient
Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Circle one

Are you under a physician's care now? No Yes Please explain: _____

Have you ever...

Been hospitalized? No Yes Please explain: _____

Had a major operation? No Yes Please explain: _____

Had a serious head/neck Injury? No Yes Please explain: _____

Are you taking any medications? No Yes Please explain: _____

Do you take or have you taken Phen-Fen/Redux? No Yes Please explain: _____

Are you on a special diet? No Yes Please explain: _____

Do you use tobacco? No Yes Please explain: _____

Do you use controlled substances? No Yes Please explain: _____

WOMEN ONLY

Are you:

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

Are you allergic to any of the following:

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Please check if you have, or have had any of the following:

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's	Diabetes	Hepatitis A	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	High Blood Pressure	Shingles
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Spina Bifida
Asthma	Fainting Spells/Dizziness	Kidney Problems	Stomach/Intestinal Disease
Blood Disease	Frequent Cough	Leukemia	Stroke
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of Limbs
Breathing Problem	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Bruise Easily	Genital Herpes	Lung Disease	Tonsillitis
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or Growths
Chest Pains	Heart Attack/Failure	Parathyroid Disease	Ulcers
Cold Sores/Fever Blisters	Heart Murmur	Psychiatric Care	Venereal Disease
Congenital Heart Disorder	Heart Pace Maker	Radiation Treatments	Yellow Jaundice
Convulsions	Heart Trouble/Disease	Recent Weight Loss	

Have you ever had any serious illness not listed above? Please Explain _____

To the best of the 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 changed in medical status.

Signature of Patient, Parent, or Guardian _____ Date:_____

Oak Park Dental

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand as we are ready to answer any of your questions or explain anything. In general terms, contemplated dental treatment includes:

Periodontal Treatment/Surgery, Root Canal Therapy, Composite or Amalgam Therapy, Crown and Bridge Care, Partial or Denture Care, Local Anesthesia, Nitrous Oxide Sedation, Oral Surgery/Extraction

Alternatives to the Recommended Dental Treatment

Any alternatives to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

Risks Associated with the Recommended Dental Treatment

I understand dentistry is not an exact science and complications may occur despite our best efforts. A partial listing of the risks known to be associated with the dental treatment and the anesthetic are:

Infection, Injuries to adjacent teeth and/or hard or soft tissue, Opening between mouth and sinus or mouth and nose, Dry Socket, Slough-unanticipated loss of hard and/or soft tissue, Breakage of root(s) and retained root fragments, Trismus- jaw pain or difficulty opening mouth, Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complications, Bleeding, Paresthesia or numbness of: tongue, and/or mouth, and/or face, tooth or fragment in maxillary sinus, Loss of teeth, Injury to adjacent structures, Swallowing and/or aspiration of objects, Failure of treatment to accomplish its purpose, Failure of wound to heal, Fracture of mandible (lower jaw) or maxilla (upper jaw), Incomplete removal of tooth, Loss of bone, Instrument, Breakage, Allergic reactions, Bacterial Endocarditis

State Law also requires that we specifically advise you that although rarely occurring, the dental treatment or anesthetic may result in: Death, Brain Damage, Quadriplegia, Paraplegia, Loss of Organ(s), Loss of Function of an organ, Loss of function of face, Arm(s), or Leg(s) and Disfiguring Scars.

Acknowledgement

The risks, benefits, and possible complications of the proposed treatment, including the risk that such treatment may not accomplish the desired objective, have been fully explained to me and I fully understand them.

I understand that the success of the dental treatment cannot be determined in advance and I acknowledge that no guarantees have been made to me regarding the results of this treatment. I acknowledge that I have read and understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given adequate opportunity to ask whatever questions I have about the treatment, all of the questions about the treatment have been answered in a satisfactory manner.
I understand the success of this treatment and avoidance of treatment complications depend to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following the instructions given to me, and keeping the appointments for treatment or follow-up visits rescheduled or recommended. I understand that I am to notify the dentist immediately of any suspected complications where future treatment may be discussed, which is not currently anticipated. I hereby authorize and direct Dr. Harry K. Castle and/or his associates or qualified professional of his choice, to perform the diagnostic, surgical, or dental procedures, including any necessary or advisable anesthetic. This Consent Form will remain valid until revoked by me in writing.

For Women: Informed Consent regarding antibiotics effect on oral contraceptives

I understand that women of childbearing age may experience reduced efficiency of oral contraceptives during antibiotic therapy. I understand the need to use additional contraceptives during the antibiotic usage. I understand that I may need to consult my physician about the possibility of higher doses of oral contraceptives and/or other contraceptive alternatives.

Date: _____ Signature of Patient/Guardian: _____

OAK PARK DENTAL

CONSENT OF DISCLOSURE

I hereby give consent to Oak Park Dental to use and disclose my protected health information for the purposes of treatment, payment and health care operations

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request; however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy.

Print Patient's Name: _____

Sign: _____ Date: _____

If you are signing as the patient's representative

Print your Name: _____

Relationship: _____

CANCELLATION

I hereby void the consent given above.

Print Patient's Name: _____

Sign: _____ Date: _____

If you are signing as the patient's representative

Print your Name: _____

Relationship: _____

Hello!

Please help us accommodate your individual dental needs by checking the appropriate options below. Thank you!

My primary reason for my visit today is:

_____ My Insurance Company suggested this dentist

_____ I'm in pain

_____ I wanted to establish myself as a patient with your practice

_____ I'm new in town

_____ I need to talk about what can be done to enhance my smile.

_____ I suffer from migraine headaches

Namely I am interested in:

_____ Full orthodontics (18 to 24 month treatment)

_____ Six month orthodontics to straighten front teeth

_____ Bleaching (Take home trays or light activated Zoom)

_____ White Fillings

_____ Veneers

_____ Anything that would help make my smile more attractive

Photo Release Form

Oak Park Dental
1616 W. McNeese
Lake Charles, LA 70605

Permission to Use Photograph and/or Video

I grant to Oak Park Dental, its representatives and employees the right to video or take photographs of me. I authorize Oak Park Dental its assigns and transferees to copyright, use and publish the same in print and/or electronically. (Initial) _____

I grant to Oak Park Dental, its representatives and employees the right to video or take photographs of my **mouth only**, showing nothing other than the teeth and the surrounding area. I authorize Oak Park Dental, its assigns and transferees to copyright, use and publish the same in print and/or electronically. (Initial) _____

I agree that Oak Park Dental may use such video or photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature _____

Printed name _____

Organization Name_____

Date _____

Signature, parent or guardian _____
(if under age 18)

Oak Park Dental Health and Safety Policy

Due to our Health and Safety Regulations only the patient is allowed in the treatment rooms while the doctor is performing the dental treatment. Please understand it is our policy and if at any time the child is in need of your assistance you will be informed.

_____

Patient

_____ _____

Patient Signature or Guardian Signature Date

OAK PARK DENTAL

PLEASE BE ADVISED WHETHER YOU HAVE INSURANCE OR NO INSURANCE, YOU MUST PAY FOR ANY DENTAL SERVICES PERFORMED FOR YOU ON THE DAY THE WORK IS COMPLETED. WE CANNOT BILL YOU AND PAYMENT IS DUE ON EACH VISIT TO THE OFFICE. WE WILL BE GLAD TO ESTIMATE WHAT YOUR COPAY WILL BE FOR YOUR NEXT VISIT SO YOU WILL BE PREPARED TO PAY AT THE TIME. PLEASE REMEMBER THIS IS ONLY AN ESTIMATE AND WE WILL NOT KNOW THE TRUE COST OF THE SERVICE UNTIL THE DOCTOR PERFORMS SAID SERVICE. WE HAVE SEVERAL PAYMENT PLANS AVAILABLE TO YOU, BUT YOU MUST MAKE PRIOR ARRANGEMENTS FOR THESE BEFORE ANY WORK IS STARTED. JUST ASK US AND WE WILL BE HAPPY TO DISCUSS THEM WITH YOU.

THANK YOU,

DR. HARRY CASTLE

I UNDERSTAND AND AGREE WITH THE ABOVE STATEMENT.

SIGNATURE _____ DATE _____

Cancellation Policy

Welcome to Oak Park Dental! From the beginning we try to establish open lines of communication. Communication is very important, so that you understand us and we understand you. First and foremost we want to make you aware that our office policy states that you must call our office to cancel an appointment at least 24 hours before the scheduled appointment. If you do not cancel your appointment at least 24 hours before you are scheduled to come in the following charges will be applied to your account.

Dr. Castle ——— $75.00 / hour
Dr. McGee ——— $50.00 / hour
Dr. Ferro ——— $50.00 / hour
Dr. Tran ——— $50.00 / hour
Dr. Duhon_____$50.00 / hour
Hygienist ——— $50.00 / hour
Orthodontics ——— $25.00 / hour

We will also call to remind you of your appointment either one or two days in advance. When we leave a message, please return our call. We could be calling for different reasons; a time/schedule change or to confirm the appointment.

We must have verbal confirmation from you in order to keep the appointment or it can be cancelled without notice.

By signing below, I confirm that I understand and agree with the policy above.

Print Patient's Name: _____

Sign: _____ Date: _____

Account Responsibility

Please be advised whether you have insurance of no insurance, you must pay for any dental services performed for you on the day the work is completed. We cannot bill you; therefore, payment is due on each visit to the office.

We will be glad to estimate what your payment will be for your visits so you can be prepared to pay at the time of service. Please remember this is only an estimate and we will not know the true cost of the service until the doctor performs said service. Any portion of the estimate that the insurance does not pay will be your responsibility.

We have several payment plans available for you; however, you must make arrangements for this prior to the start of any dental treatment. Please ask our staff and they will be happy to discuss these options with you.

By signing below, I confirm that I understand and agree with the policy above.

Print Patient's Name: _____

Sign: _____ Date: _____

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

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

_____

{Signature of Patient and/or Guardian} {Date}_____

{Relationship to Patient} Self or Other: _____

I, _____, acknowledge and allow Oak Park Dental to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call [ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call OR

[ ] you may e-mail me at _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

HIPAA Notice of Privacy Practices
Oak Park Dental

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (such as Family members, etc.). We will also disclose to a family member, spouse, adult children, and information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extend necessary to help with your healthcare and/or with payment for your healthcare.
For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. An another example would be when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of
Section 164.500.

Your rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **We will not retaliate against you for filing a complaint.**

This notice was published and became affected on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person, (Name of HIPAA Officer or by phone at our main phone number (Office Phone Number).

Oak Park Dental

HIPAA RELEASE OF DENTAL INFORMATION for a MINOR

Patient Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination, pre-op and post op instructions rendered to my child(ren) and claims information. This information may be released to:

[ ] Spouse (Parent) _____

[ ] Other (Grandparent – other Guardian, etc. _____

I do not authorize any release of information to the following people:

[ ] Spouse (Parent) _____

[ ] Other (Grandparent – other Guardian, etc. _____

This **Release of Information** will remain in effect until terminated by the guardian in writing.

Messages

Please call [ ] home phone [ ] my cell number

_____ _____

If unable to reach:

[ ] you may leave a detailed message [ ] please leave a message asking for a return call

The best time to call is (day) _____ between (time) _____

Guardian Signature: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____