PLEASE NOTE: Please Print, Fill Out, and Bring These Forms With You to Your First Visit. After Printing, Please Click the "Back" Button If You Need To Return to the Website.

Ken D. Ray, D.D.S., M.S., Inc.

5010 EAST 68TH STREET TULSA, OKLAHOMA 74136 TELEPHONE (918) 492-7581

PERIODONTICS

TO OUR PROSPECTIVE PATIENTS

On behalf of the staff I would like to welcome you to our office. Today we will perform a complete examination of your mouth, particularly detailed in those things related to periodontal disease. This will include a careful visual inspection of your gums and teeth, an examination of your X-rays, and your occlusion (bite) and perhaps other records such as diagnostic models. To aid in the complete evaluation of your dental problems and to plan the best treatment for you, it is important to obtain certain information about your dental and medical history.

Name: _____ Age: _____ Date: _____

Dental History:

Are you experiencing pain in your mouth now? _____

Have you had previous periodontal (gum) care? _____

When and where? _____

When did you last have your teeth cleaned? _____

How often have you had your teeth cleaned in the last 10 years? _____

How often do you brush your teeth? _____

Have I treated any of your friends or family? _____

	Yes	No
Have you had swollen areas of the gums?		
Do your gums bleed?		
Have you noticed any loose teeth?		
Have you noticed any bad odors or tastes?		
Have you ever had trench mouth?		
Are your teeth sensitive to hot, cold, or sweets?		
Have your front teeth separated, creating spaces?		
Do you use either dental floss or gum stimulators daily?		
Have you worn braces to straighten your teeth?		
Would you be tremendously disturbed if you had to lose your teeth and wear false teeth?		
Are you satisfied with the appearance of your teeth?		
Are you aware of clenching, gritting or grinding your teeth either during the day or at night?		
Do you have headaches regularly? Mornings or evenings?		
Have you ever had an extremely frightening experience with dentistry?		

Do you have dental insurance? _____

If so, who _____

HEALTH QUESTIONNAIRE

Date _____

Name _____ Address _____
Last First Middle Number & Street

City State Zip Code Home & Business Phone

Date of Birth Height Weight Occupation

Married Spouse Single

Closest Relative Phone

If you are completing this form for another person, what is your relationship to that person?

_____

PLEASE ANSWER EACH QUESTION CIRCLE

1. Have you been a patient in a hospital during the past 2 years? Yes No
2. Have you been under the care of a physician during the past 2 years? Yes No
3. Have you taken any kind of medicine or drugs during the past year? Yes No
4. Are you allergic to penicillin, codeine or any other drugs or medicine? Yes No
5. Have you ever had any excessive bleeding requiring special treatment? Yes No
6. Circle any of the following which you have had:

heart trouble	jaundice	arthritis
congenital heart lesions	asthma	stroke
heart murmur	cough	epilepsy
high blood pressure	diabetes	psychiatric treatment
anemia	tuberculosis	sinus trouble
rheumatic fever	hepatitis	

7. (Women) Are you pregnant now? Yes No
8. Have you had any other serious illnesses? Yes No

TO BE ANSWERED ONLY BY PATIENTS RECEIVING SEDATION OR GENERAL ANESTHESIA.

9. Have you had anything to eat or drink within the last 4 hours? Yes No
10. Are you wearing removable dental appliances? Yes No
11. Are you wearing contact lenses? Yes No
12. Who is to drive you home today?

    a. Name _____

Reviewed by Signature _____

Dental insurance verification

Today's Date_____

Patient's name_____

Home phone #_____ Work#_____

Patient's social security #____-____-_____ Patient's D.O.B.____-_____-____

If patient is 18 years old or older-FULL TIME STUDENT Yes / No

Insured name_____Patient's relatioship to insured_____

Insured social security #____-____-_____ Insured D.O.B.____-____-____

Insured employer_____ Work #_____

Insurance company_____ Phone#_____

Group #_____ Policy #_____ Employee #_____

(OFFICE USE)

Effective date if insurance_____ Dependent coverage_____

Individual deductible$_____ Family deductible$_____

Deductible apply to preventice Yes / No Carry over Yes / No

Annual maximuim$_____ Balance of maximum available_____

Benefit year-Calander / Fiscal Payor ID#_____

Mailling address_____

_____

_____

Preventive services_____% Cleaning per year_____

Fluoride age limit and times per year_____

Full mouth x-rays& bitewings (time limit)_____

Basic services_____%Periodontics_____%Major_____%Endontics_____%

Oral surgery_____%Predetermination mandatory---------- Yes / No

Waiting period for major work----------Yes / No

Contact name insurance company_____Extension_____

Ken D. Ray, D.D.S., Inc.
Periodontics

OFFICE FINANCIAL POLICY

Forms of payment: We accept MasterCard, Visa, Discover, personal checks or cash.

I, the understand, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information.

I authorize Dr. Ray to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. It is the patients responsibility to know their own insurance benefits.

I understand that my dental/medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents or charges.

All initial or pre-surgical treatment fees are to be taken care of at the time of treatment.

All pre-surgical therapy fees must be paid before surgery appointment is scheduled.

Surgery fees can be handled in one of the following ways:

A) Cash payment
B) MasterCard, Visa or Discover
C) 1/3 payment at surgery appointment, then equal payments in 30 and 60 days.
D) Patients with assignable insurance that have a pre-treatment estimate, can bring an assigned insurance claim form along with 30% of the surgery fee and we will file the claim and await up to 60 days for payment from the 3rd party carrier, if insurance has not paid, then the balance is the patients responsibility.

We will file your secondary insurance as a courtesy, but payment after primary carrier has paid is the responsibility of the patient/guarantor of the account and is subject to finance charge.

A finance charge of 1 1/2% per month (18% apr) will be charged on all past due patient portion balances.

CANCELLATIONS AND MISSED APPOINTMENTS

Please help us to keep costs down and serve all our patients better by giving sufficient notice of a cancellation. Most of our regular treatment appointments are 45 minutes to 1 hour in length. That time is reserved for you. **It is necessary that we receive 24 hours notice for a cancellation of a treatment appointment, 48 hours notice for a late-day appointment (after 3:00 pm), and 72 hours notice for a cancellation of a surgical or multi-hour appointment. Please do not include week-ends or holidays as notice time, only business hours are acceptable notice.**

PATIENTS WILL BE CHARGED FOR THIS TIME UNLESS WE ARE GIVEN SUFFICIENT PRIOR NOTICE.($1.00 per scheduled minute with Dr. Ray, $ .50 per scheduled minute with the hygienist)

I ACKNOWLEDGE THAT THIS INFORMATION WAS PRESENTED TO ME AND I RECEIVED A COPY FOR MY RECORDS.

Signed_____ Date_____

5/96

5010 East 68th Street • Suite 204 • Tulsa, Oklahoma 74136 • (918) 492-7581

Dr. Ray's Office Policies

1.5% finance charge on past due patient portion balances.

Claremore patients must give 3 working days notice of a cancellation.

Patients will be charged for their appointment time unless we were given sufficient notice at the following rates.

$1.00 per scheduled minute.

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
KEN D. RAY D.D.S., M.S.

I_____ acknowledge that I have received a copy of the Notice of Privacy Practices of Ken D. Ray, and a copy of this acknowledgment.

If you have any questions please contact the privacy officer whose name and contact information is listed below.

_____
Name of Patient or Personal Representative (Printed)

_____
Signature of Patient or Personal Representative

_____
Date

_____
Personal Representative's Relationship or Authority

Privacy Officer:
Ken D. Ray D.D.S., M.S.
5010 E. 68th st Ste 204
Tulsa, Okla. 74136
(918)492-7581