Parkway Dental Group
www.parkwaydentalokc.com
3727 NW 63rd | Ste 107 • OKC, OK 73116
office@parkwaydentalokc.com
(405)810-8995

Patient Information

Social Security # ______________________

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: ______________
FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________ **Prev. Visit:** ________ **Email Address:** ______________________

Phone: ________ Home ________ Mobile ________ Work ____ Ext **Best time to call:** ______________

Address: ______________________ Address 1 ______________________ Address 2

______________________ City ____ State _____-____ Zip Code

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Morning ☐ Afternoon ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________ **Email Address:** ______________________

Phone: ________ Home ________ Mobile ________ Work ____ Ext **Best time to call:** ______________

Address: ______________________ Address 1 ______________________ Address 2

______________________ City ____ State _____-____ Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________ **Phone:** ____________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________ **ID #:** ____________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________ **ID #:** ________________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

For our patients utilizing dental insurance: By signing below you are authorizing your benefits to be paid directly to Dr. Kuker and her office. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also authorize Dr. Kuker and office or insruance company to release any information required to process my claims. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature ______________________________ **Date** ____________

Relationship to Patient:

____

____

Response Date: ____/____/________

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Medical History

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Medical Alerts

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Abnormal Bleeding
☐ Alcohol Habit	☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Erythro	☐ Allergy - Hay Fever	☐ Allergy - Latex	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy- Food	☐ Allergy-Barbituates
☐ Allergy-Local Anesth	☐ Allergy-Tetracycline	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Back Problems	☐ Blood Disease
☐ Cancer	☐ CardiovascularDiseas	☐ Chemical Dependency	☐ Circulatory Problems
☐ Diabetes	☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Glaucoma	☐ Headaches/Migraines	☐ Heart Disease
☐ Heart Murmur	☐ Heart Problems	☐ Hepatitis	☐ Herpes
☐ High Blood Pressure	☐ HIV	☐ Jaw Disorder	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders	☐ MVP
☐ Nervous Disorders	☐ Other	☐ Pacemaker	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Stomach Problems
☐ Stroke	☐ Tobacco Habit	☐ Tuberculosis	☐ Venereal Disease/STD

Physician's Name, Address, Phone number

____

____

Have you ever had a serious illness or operation? If yes, describe

____

____

Have you ever taken any of the group of drugs referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) *

◯ Yes ◯ No

Are you pregnant? Nursing? * ◯ Yes ◯ No

Medications

Please list all medications you are currently taking:

____

____

To the best of my knowledge, the above information is complete and accurate. I understand it is my responsibility to inform my doctor if I or my minor child has a change in the medical condition.

Signature ____ **Date** ____________

Response Date: ____/____/________

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Acknowledgment of Receipt of Notice of Privacy Practices

I, ___________________________________(patient's name) understand that as a part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that this facility reserves the right to change their Notice of Privacy Practices and that I have the right to reveiw this facility's Notice of Privacy Practices prior to signing this acknowledgement.

I would like to authorize the release of my medical/dental information to the following individuals

____

____

I authorize the doctor and staff to communicate with me via:

☐ Text Message ☐ Email ☐ Voicemail

I understand that these communications may contain medical/dental information

Signature ____ **Date** ____________

Above provide the Signature of Patient or Legal Representative.
Below provide the Printed Name of Patient or Legal Representative.

____

____

Response Date: ____/____/________

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Consent for Internet Communications

Patient Name: ______________________ ______________________ ___ ______________________

Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature of patient, parent, or guardian:

Signature ____ **Date** ____________

Relationship to Patient:

____

____

Response Date: ____/____/________