midtownsmiles

3150 E. 41st St., Suite 131, Wellington Square Building • Tulsa, Ok 74105
(918) 749-1639 • Fax (918) 749-0416 • info@midtownsmilestulsa.com

Patient Information

Patient Name____
Address__________________________City____________State____Zip _____
Date of Birth____________Social Security ____________ Sex - Male ____ Female____
Marital Status- Married_____Single_____Divorced_____Seperated_____Widowed____
Home Phone______________Cell Phone______________Work Phone______________
Employment Status – Full Time_____ Part Time_____ Retired_____
Employer & Address____
Student Status – Full Time____ Part Time_____ Name of School___________________
Personal Email_________________________Work Email_________________________
Spouse Name_______________________Spouse Employer_______________________
Spouse Employer Address & phone #____
Emergency Contact Name & Phone #____

Referred By_________________________________***Phone***______________________

Billing Name/Responsible Party & Address (if different from Patient)

Patient Name____
Address__________________________City____________State____Zip _____
Home Phone______________Cell Phone______________Work Phone______________
Date of Birth_________________Social Security ______________________________
Personal Email_________________________Work Email_________________________
Spouse Name_______________________Spouse Employer_______________________

Pharmacy Name, Location & Phone # _______________________________________

Primary Insurance Information

Name of Insurance____
Name of Policy Holder______________________Relationship to Patient_____________
Insurance Address____
Insurance Phone #_________________________Employer________________________
ID# or Social Security #_______________________Policy Holder DOB_____________

PLEASE LET US KNOW IF YOU HAVE SECONDARY INSURANCE.

Authorization to release information to insurance companies.
Authorization for insurance to pay Midtown Smiles.

Signature____**Date**_______________

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______

Do you have, or have you had, any of the following?

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______

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 ______________________ DATE ____________

Midtown Smiles
3150 E. 41st Street, Suite 131
Tulsa, OK 74105

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 05/01/2017, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location. We will otherwise distribute it upon request.

You may request a paper copy of our Notice at any time by contacting our Privacy Official.

Your Authorization: In addition to our use of your health information as described in this Notice , you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician, pharmacist, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with conducting our practice. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities, financial matters, legal matters and business planning and development.

To You Or Your Personal Representative: We must disclose your health information to you, as described later in this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose protected health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may disclose your information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, letters, texts or emails).

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration; to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence counterintelligence,and other national security activities . We may disclose to correctional institutions or law enforcement officials having lawful custody the protected health information of an inmate or patient under certain circumstances.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Access: You have the right to look at or get copies of your health information, with Limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot predictably do so. You must make a request in writing to obtain access to your health information by sending us a letter to the address at the end6 f this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, including any postage. If you request a alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary 11 or an explanation of your health information for a fee.

Disclosure to Business Associates: We may disclose your information to our third-party service providers that perform functions on our behalf or provide us with services. 'For example, we may use a business associate to assist us in maintaining our practice management software. Our business associates are obligated to protect the privacy or your information .

Disclosure Accounting: You may request, in writing, an accounting of disclosures of your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for 6 years prior to the date that the accounting is requested. If you request an accounting more than once in a 12 -month period, we may charge you a reasonable, cost based fee for responding to the additional requests .

Security: You will be notified if the security of your personal health information is breached.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information . In most cases we are not required to agree to these additional restrictions,except if you have paid out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer for reimbursement. We will honor that request.

Other Use or Disclosure: Your protected health information that involves the release of psychotherapy notes, marketing, sale of your information or other uses or disclosures not described in this notice will be made only with your with en authorization, unless otherwise permitted or required by law. You may revoke your authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of such authorization.

Special Protections: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain information, including information related to HIV, alcohol and substance abuse, mental health and genetics. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information .

Alternative Communication: You have the right to request, in writing, that we communicate with you about your health information by alternative means or at alternative locations. Your request must specify the alternative means or location on, and provide satisfactory explanation of how payments and communication will be handled under the alternative means or location you request.

Amendment: If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and ca file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree wit a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Official: Elizabeth Roberts Telephone: 918-749-1639 Mailing Address: 3150 E. 41 st Street, Suite 131
Tulsa, OK 74105

Midtown Smiles
3150 E. 41st Street, Suite 131
Tulsa, OK 74105

Authorization to Release Protected Health Information

Patient's Name: ____ Date of Birth: ________________

I __________________________________authorize C. Shaun Mirabal, DDS and/or Rebecca Hughes, DDS to release the named patient's protected health information. This may include the entire contents of the dental record, diagnosis, treatment and financial information.
This information may be released to:

[ ] Name____relationship_____________

[ ] Name____relationship_____________

[ ] Name____relationship_____________

[ ] Name____relationship_____________

Purpose of this use or disclosure:
[ ] At the request of patient
[ ] Other, description____(Privacy Official may be involved)

I understand that I may revoke this Authorization at any time by notifying this office in writing. Such revocation will not affect any use or disclosure permitted by my authorization while it was in effect.
I also understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected.
I understand that my healthcare provider cannot condition treatment on whether or not I sign this Authorization.

This Authorization will remain in effect until:
[ ] Terminated by me, in writing.
[ ] The above named patient turns age 18, or is no longer a patient.
[ ] Other, description of specific event relating to above described use/disclosure_______________
____

Signed: ____Date: ___________________
Relationship: [ ] Self; [ ] Parent; [ ] Guardian; [ ] Legal Representative

____
__________________________________**For Office Use Only**________________________________

Copy of signed authorization provided to the individual, date:________________initials:_________

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FINANCIAL ARRANGEMENTS & INSURANCE

Dr. Mirabal, Dr. Hughes and staff are committed to providing you with the best possible care. If you have dental insurance we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time of service unless payment arrangements have been approved in advance by our staff. We accept Cash, Checks, Visa, MasterCard, American Express, Discover and Care Credit. Dr. Mirabal and Dr. Hughes are a provider for Delta Dental Premiere, Blue Cross Blue Shield Traditional, Humana, MetLife, Cigna, Aetna and Guardian.

You Must Realize:

1. **Your insurance is a contract between you and your employer, and the insurance company.** We are not a party to that contract.
2. Our fees are generally considered to fall within an acceptable range by most companies, and therefore, are covered to the maximum allowance determined by each carrier.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.
4. All co-pays, deductibles, and/or previous balances are due at the time of service.
5. If your account is turned over to collections, your personal information, including your cell phone number, will be released to the collections agency.
6. **24-hour cancellation fee policy:** We reserve the right to charge you, the patient, a cancellation fee (amount to be determined by the length of appointment and procedure) with a less than 24-hour cancellation notice. **Please note our office is not open on Fridays, therefore, Monday appointments must be cancelled during business hours on the Thursday before, to avoid a cancellation fee.**

We must emphasize financially that our relationship is with you and not your insurance company. While the filing of certain insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date the services are rendered. Patients are asked to monitor their insurance payments and promptly pay any remaining balance. If we do not hear from your insurance company within 30 days, you will be responsible for payment. If any such problems arise, we encourage you to promptly contact us for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you. Our office telephone number is (918) 749-1639. Or email us at: info@midtownsmilestulsa.com.

I hereby authorize C. Shaun Mirabal, DDS and/or Rebecca Hughes, DDS to furnish information to insurance carriers concerning my dental treatment, and I hereby assign to the doctor all payments for dental services rendered to myself or my dependants. I understand that I am responsible for all charges.

Financially Responsible Party Signature: __________________________ Date: ____________

SMILE EVALUATION

1. Do you like the way your teeth look? Yes___ No___
   Explain:____
2. Are you happy with the color of your teeth? Yes___ No___
   Explain:____
3. Would you like your teeth to be whiter? Yes___ No___
4. Would you like your teeth to be straighter? Yes___ No___
5. Are there spaces between your teeth that you would like to close?
   Yes___ No___ If so where?________________________________
6. Have you ever considered Orthodontics? Yes___ No___
   Explain:____
7. Do you like the shape of your teeth? Yes___ No___
   Explain:____
8. Do you have missing teeth that you would like to replace? Yes__ No__
9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
   Yes___ No___
10. Do you wake up with headaches or tension in your neck from grinding?
    Yes___ No___
11. If you could change anything about your smile, what would it be?
    ____
    ____
12. Is there anything your dental team should know prior to seeing you?
    ____
    ____

ASK US ABOUT FAST BRACES & OUR VIP SMILE PROGRAM!!!!