PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Phone #

Relation to Patient

Custodial Guardian

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

OUCP Dental Service

OUCP Dental Clinic Medical History(Copy)

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, 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
Do you have a primary care physician? If so, please list.	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
Do you use tobacco?	Yes No	

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

Any other Food or Drug allergies? Yes No 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	Neurological Disorder Yes No	Venereal Disease Yes No
Yellow Jaundice Yes No			

Have you ever had any serious illness not listed above?	Yes No	If yes
Do you take aspirin daily or any other blood thinner?	Yes No	If yes

To be completed by Doctor:

Was patient referred by a Dentist or Physician?	Yes No	If yes
Any special precautions prior to dental treatment? IF YES, PLEASE DESCRIBE.	Yes No	If yes

ASA Classification:

I II III

IV V VI

BP:

Pulse:

Respiration:

Pulse Ox:

Weight:

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:_____

Patient Name_____
Birthdate_____

OU PHYSICIANS
COMPREHENSIVE PATIENT CARE CONSENT & AUTHORIZATION

I understand that this OU Physicians Comprehensive Patient Care Consent & Authorization applies to my visits, or my child's visits, at all OU Physicians locations.

GENERAL CONSENT FOR TREATMENT I voluntarily consent to receive care encompassing physical examinations, diagnostic procedures and medical treatments by an OU Physicians provider and/or their assistant as deemed necessary for myself or minor child.

_____ Initial

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS I understand that OU Physicians will release information to my insurance company necessary to secure payment for services rendered and assign payment of my insurance benefits to OU Physicians and other providers for such services. If I am an OU student, I consent to the release of my treatment & education records to my insurance carrier or payer for payment for services rendered and authorize carrier/payer to pay OU Physicians and other providers for such services.

_____ Initial

FINANCIAL AGREEMENT AND PAYMENT RESPONSIBILITY I acknowledge that I am responsible for all charges incurred, regardless of insurance status. I agree to pay for services as they are provided and/or pay promptly upon receipt of a statement. I have received a copy of and agree to OU Physicians' Patient Rights and Responsibilities.

_____ Initial

PRESCRIPTIONS I consent to OU Physicians' accessing prescription databases to review my or my child's prior and ongoing prescription history. I may revoke this consent by notifying OU Physicians in writing. If I do not provide consent or if I revoke this consent, I may be terminated as an OU Physicians patient.

_____ Initial

COMMUNICATION METHODS OU Physicians providers want to assure that they effectively communicate in a manner that best suits their patient's needs. I have been advised that OU Physicians is able to provide appointment reminders via secure email, unsecure text and telephone. Unsecure texts may be intercepted by unauthorized individuals, but I elect to receive texts, if used by my clinic(s). I understand that I have the option to choose the best communication method for my needs and may change that method as needed.

_____ Initial

I acknowledge that OU Physicians may send me educational health materials and patient satisfaction surveys by email.

_____ Initial

LEAVING MESSAGES There are times when we may not be able to reach you and need to leave a message or we may send automated appointment reminders via automated calls. We may use your or your minor child's information to contact you and leave a message that includes information about you or your child's health, appointment time and location, or the clinic or provider name.

_____ Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES I acknowledge that I have been provided the University of Oklahoma's ("OU") Notice of Privacy Practices ("Notice"). It tells me how OU will use my or my child's health information for the purposes of my or my child's treatment, payment for my or my child's treatment, and OU's health care operations. The Notice also explains in more detail how OU may use and share my or my child's health information for other than treatment, payment and health care operations. OU will also use and share my or my child's health information as required/permitted by law.

_____ _____
Signature of Patient, Parent or Legally Authorized Representative* Date
**May be requested to show proof of representative status.*

I understand and attest that the information on this form has been reviewed with me in its entirety. I understand that this document is effective indefinitely unless revoked.

Email Address_____