Dr Colpitts Wellness Center

2448 E. 81st St., Suite 1600
Tulsa, OK 74137
(918) 477-9000 Fax (918) 477-9056

PATIENT INFORMATION: **Today's date: _____**

Name (first/last):_____ Preferred Name: _____

If minor, Guarantor's Name: _____ & ***Date of Birth***: _____

Male ____ Female ____ Single ___ Married ___ Divorced ___ Widowed ___ Minor ___

Date of Birth: ____/_____/_____ Social Security #:_____

Home address: _____City: _____ St: ____ Zip:_____

E-mail address: _____

Home phone: _____Work phone: _____ Cell phone: _____

Place of Employment: _____

Major complaint or reason for today's visit: _____

_____

Have you been seen for this condition: Y or N Date:_____ What was done:_____

_____

Date of last dental appt: _____For what? _____ _____ _____

Cleanings per year: _____ Date of most recent: _____ Have you had Perio Disease?: Y or N

How did you find us?_____

In case of emergency please notify:

Name: _____ Relationship: _____ Phone: _____

In consideration of the services rendered to me by this office, I am obligated to pay said office in accordance with its credit terms and policy. **All today's procedures are expected to be paid in full: credit card, check, cash, payment plans available via Care Credit**

DENTAL INSURANCE INFORMATION

To be completed if you have Dental Insurance—***Medicare and Health*** insurance do not pay for our services.

Please give your Dental Insurance card to the front desk person.

We will NOT be able to file dental insurance for you UNLESS we have a copy of the insurance card.

We do not accept assignment of insurance benefits; payment in full is due on the day of the appointment.

Primary Dental Insurance

Name of person that carries coverage: _____D.O.B._____

Social Security#:_____

All insurance re-imbursements will be paid directly to you

Assignment & Release: I authorize the dentist to release any information required for this claim

Patient or Guarantor's signature: _____

Please complete the medical questionnaire on back-side of this form

MEDICAL HISTORY

Primary Physician Name: _____ MD or DO or DC
Address **(city/state):**_____ **Telephone:**_____

Please **check** the following if it applies to you:
____ Ever had or have Hepatitis Type:____ When?_____
____ Epilepsy
____ Rheumatic fever
____ Scarlet fever
____ Heart murmur or mitral-valve prolapse
____ High Blood pressure
____ Have you been told (by physician) to take an antibiotic prior to a dental appointment
____ Kidney or liver disorders or disease
____ Diabetes Type: _____ Insulin dependent: Y or N Date Diagnosed:_____
____ Cancer Type :_____ Date of Chemo:_____ or Radiation:_____
____ TIA or Stroke
____ Heart trouble Heart attack: Y or N Stent: Y or N Date:_____
____ Stomach ulcer
____ Thyroid disorder
____ Smoking How much per day:_____ How many years: _____Quit?_____
____ Prolong bleeding due to procedures or a slight cut
____ Immune deficiency (AIDS or HIV)
____ Psychiatric treatment or emotional problems
If you are a **female**: pregnant Y or N taking birth control pills Y or N taking hormones Y or N

Allergies or reaction to:
____ penicillin ____aspirin _____ erythromycin ____tetracycline ____codeine
____ sedative ____ dental anesthetic ____ latex
____other medication, list and describe:_____

Any type of disability; please describe:_____

List of current prescription medications:_____
(If lengthy, please provide on a separate sheet).

Are you on a detox regime? Y or N What:_____

Any other medical conditions not listed above _____

Consent to Share Information

I consent for Dr. Colpitts to share my personal information, especially with regards to my dental diagnosis and treatment, with the following people and, if applies, to my dental insurance company.
1._____ 2._____
3._____ 4._____

Print Patient Name: _____ Date: _____

Patient or Guardian Signature: _____