

ACQUAINTANCE RECORD

We welcome you and your family into our practice. Please complete this form as thoroughly as possible. Thank you!

Mr. / Mrs. / Miss / Ms. / Dr. / Rev.

Patient's Name _____ Nickname _____ Sex M / F

Age _____ Date of Birth _____ SSN _____

DL # _____ E-Mail _____
(for appointment Confirmations)

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Name of Employer (School if full time student) _____

Marital Status: Single / Married / Divorced / Widowed / Separated / Partnered

Name of Spouse/Significant Other _____ DOB _____ Age _____

Spouse's Employer _____ Cell Phone _____ SSN _____

In Case of Emergency-Contact _____ Phone Number _____

Nearest Relative Not Living with you _____ Phone Number _____

Whom may we thank for referring you to our office? _____

IF PATIENT IS A CHILD (UNDER 18 YEARS OLD OR COLLEGE STUDENT) PLEASE COMPLETE FOLLOWING SECTION:

Lives with Mother / Father / Both / Other _____

Father's Name _____ DOB _____ SSN _____

Address _____ DL # _____
(city, state, zip code)

Cell Phone _____ Home Phone _____ Work Phone _____

Employer's Name and Address _____

Mother's Name _____ DOB _____ SSN _____

Address _____ DL # _____
(city, state, zip code)

Cell Phone _____ Home Phone _____ Work Phone _____

Employer's Name and Address _____

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR FULL PAYMENT AND THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

RESPONSIBLE PARTY'S SIGNATURE _____ **DATE** _____

MEDICAL HISTORY

PATIENT NAME _____

Name of Physician: Dr. _____ City/State _____ Phone # _____

Have You Had Any **Allergic Reactions** or Adverse Reaction, To Any Medications? **Y / N** Please List:

Please List **ALL Medications** You Are Taking and Why (Including Over-the-Counter and Herbal):

Do You Use Any Illegal Recreational Drugs (VERY important – complete confidentiality) **Y / N**

Have You Ever Had or Presently Have?

Heart Disease/Attack/Surgery	Y/N	Ulcers	Y/N	Hepatitis	Y/N
Heart Murmur	Y/N	Diabetes	Y/N	HIV or AIDS	Y/N
Mitral Valve Prolapse	Y/N	Thyroid Problems	Y/N	Hemophilia	Y/N
Artificial Heart Valve or Stent	Y/N	Emphysema	Y/N	Liver Disease	Y/N
Stroke	Y/N	Asthma	Y/N	Epilepsy or Seizures	Y/N
Cancer	Y/N	Latex Sensitivity	Y/N	Psychological Care	Y/N
Artificial Joints	Y/N	Allergies	Y/N	Kidney Trouble	Y/N
Tuberculosis	Y/N	Radiation/Chemo	Y/N	High Blood Pressure	Y/N

Any Other Disease, Medical Conditions or Problems Not Listed?

Have You Ever Been Told You Should Pre-medicate with Antibiotics Prior to Dental Treatment? **Y / N**

Preferred Pharmacy? Name _____ Phone # _____

Do You Smoke or Use Tobacco in Any Form? **Y / N** If so, For How Long and How Often? _____

Women: Are you Pregnant? **Y / N** _____ months, Nursing? **Y / N** Take Birth Control Medication? **Y / N** _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient / Guardian Signature _____ Date _____

DENTAL HISTORY

PATIENT NAME _____

Name of Previous Dentist: Dr. _____ City/State _____

Approximate Date of Your Last Visit and what was done: _____

Why Have You Left Previous Dental Office? _____

Have You & Your Previous Dentists Ever Developed a 'Comprehensive Plan' to Get Your Mouth Healthy and Keep It Healthy? **Y / N** _____

Have You Ever Had: Orthodontics/Braces/Invisalign **Y / N** Age? _____

Oral Surgery **Y / N** Age? _____ Why? _____

Gum Treatment **Y / N** When & Where? _____

Implants **Y / N** When & Where? _____

Denture or Partial? **Y / N** When? _____

TMJ Treatment or Night Guard? **Y / N** _____

PRESENT DENTAL HISTORY

Are you having Dental Pain Now? **Y / N** Where? Please describe: _____

Any Sensitivity to Hot? **Y / N** to Cold? **Y / N** to Biting? **Y / N** to Sweets? **Y / N** Other? _____

Are you missing any teeth? **Y / N** If so, Where? _____

Do your gums bleed when brushing? **Y / N** Does food become caught between your teeth? **Y / N** Where? _____

Do you notice Jaw clicking/popping? **Y / N** how often do you have headaches? _____

On a scale 1-10 ("1" meaning Not Nervous & "10" meaning Very Nervous), how would you rate your feeling for having dental procedures performed on you _____

FUTURE DENTAL OPTIONS

Are You Satisfied with the Appearance of Your Smile? **Y / N** If Not, What Would You Like to Change? _____

Do You Have Any Interest in:

Replacing Older Silver Mercury Fillings with White Composites? **Y / N** _____

1-Appointment Crowns using CEREC Technology? **Y / N** _____

Correcting Misaligned Teeth with Clear *Invisalign* or *Invisalign Teen*? **Y / N** _____

Implants to Replace Missing Teeth? **Y / N** _____

Whitening Your Teeth? **Y / N** _____

Treatment for Canker Sores / Fever Blisters / Gum Disease using Laser Technology? **Y / N** _____

Cosmetic Porcelain Veneers / Inlays / Onlays / Crowns? **Y / N** _____

Sedation Dentistry – pill to completely relax & doze through your dental treatment? **Y / N** _____

Nitrous Oxide ('*laughing gas*') – to help you relax through your dental treatment? **Y / N** _____

Sealants – preventive procedures which are totally painless and simple to apply? **Y / N** _____

Is There Anything Else about Your Dental Treatment That You Would like Us to Know? **Y / N** _____

Patient / Guardian Signature _____ Date _____

CONSENT FOR TREATMENT AND FINANCIAL POLICY

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF INSURANCE BENEFITS

I authorize Dr. Argo or staff to submit claims for payment for services to the health care services plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits. Further, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. I understand that neither Dr. Mark Argo nor his team members are responsible for my insurance coverage, nor for ensuring their payment(s) for my treatment. Any BALANCE remaining due to underpayment or lack of payment by my insurance company will be my responsibility to pay in full.

Patient/Guardian: _____ **DOB:** _____

SS # _____ **DL #** _____

DENTAL INSURANCE INFORMATION

Name of **Primary Insurance Holder** _____

Relation to Patient _____

SSN _____ EmployerName _____

Group Number _____ Dental Insurance Phone Number _____

Dental Insurance Company & Address _____

Name of **Secondary Insurance Holder** (if applicable) _____

Relation to Patient _____

SSN _____ Employer Name _____

Group Number _____ Dental Insurance Phone Number _____

Dental Insurance Company & Address _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Dr. Argo or staff to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, or association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall remain effective until revoked by this office in writing. I know that I have the right to receive a copy of this authorization if requested

CONSENT TO TREATMENT

PLEASE INITIAL 1-6 BELOW

1. _____ I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, diagnose laser and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (the patient named below) dental needs.
2. _____ upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. _____ I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. _____ I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless prior arrangements have been made. In order to obtain extended financial arrangements, I agree to allow my in-office payment history to be examined. In the event payments are not received by agreed upon dates, I understand that a delinquent payment charge of \$10.00 will be assessed each month a payment is delinquent. I also understand that my account may be assessed a service charge of 1-3/4% (21% APR) for balances older than 90 days. I am aware, should my account be in default or "collections", a collection fee of up to 33% of the balance will be added. I also understand an insufficient funds charge of \$35 may be added to my account for any returned payments. I am aware that payments may be made with cash, check, VISA, MasterCard, Discover or American Express. I also realize that 3rd party credit is possible, such as Care Credit, and that Dr. Argo is not responsible for their administration. I am aware that my records will not be released until a zero (0) balance is on the account.
5. _____ I am aware that there will be a \$50 broken appointment fee for any missed or canceled appointments with less than 48 hours' notice, following 3 or more broken appointments.
6. _____ In the event of financial arrangements or payments by phone; I hereby authorize Mark Argo DDS to retain this signed form, with my signature on file, and charge the agreed amount to my charge card.

Print Patient Name: _____ **Date:** _____

Patient / Guardian Signature: _____ _____

(Relationship to patient)

Staff Initials: _____

Mark Argo, DDS
8500 N 129th E Ave, Owasso, OK 74055-7168
(918) 274-8500
(918) 274-8522 fax
info@markargodds.com

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that his organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Patient Signature: _____ Relationship to Patient: _____

I give permission to the following individuals to access my records and to discuss my records with Dr. Argo or any of our staff:

Signature: _____ Date: _____

Office Use Only Below

Please state below that this office did attempt to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as stated below:

Staff Initials _____

Date: _____



MARK ARGO, DDS

IMPLANTS · INVISALIGN · GENERAL & SEDATION DENTISTRY

Appointment Cancellation Policy

At Mark Argo, DDS we strive to have timely appointments available for patients that need to be seen quickly. Therefore, **we request that our patients notify the office as soon as possible if you will be unable to keep your scheduled appointment.** We certainly appreciate that emergencies such as illness, etc., do occur and remain sensitive to the challenges of everyday life.

We also feel that it is important to emphasize the importance of timely communication that benefits all our patients. With timely notification of a schedule change, we reserve the opportunity to give another patient an appointment when he/she needs it most.

Finally, just as we wish to build a practice culture of generous self-care from a dental perspective, we are also committed to creating a culture of timeliness and courtesy so that our patients can juggle life's commitments with minimal inconvenience.

In support of these goals, we have documented the existing Appointment Cancellation Policy, which is the model commonly used by most dental practices in the area, as follows:

There may be a **\$50 fee assessed for an appointment missed or cancelled less than 48 hours in advance.**

We absolutely appreciate your commitment to your dental health and your trust in us as a practice! If you have any questions at all about this policy, please do not hesitate to ask.

I have read the above information regarding the Appointment Cancellation Policy and agree to its terms.

Name (please Print): _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the HIPAA Compliance Officer:

For Patient to Keep for Their Records

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
 HIPAA Compliance Officer
 Nanette Winn
 Mark Argo, DDS
 8500 N 129th E Ave
 Owasso, OK 74055-7168
 (918) 274-8500 – Phone
 (918) 274-8522 – Fax
info@markargodds.com – E-mail

For more information about HIPAA or to file a complaint:
 U.S. Department of Health & Human
 Services
 Office of Civil Rights
 200 Independence Avenue, S.W.
 Washington, D.C. 20201
 (202) 619-0257
 Toll Free: 1-877-696-6775

For Patient to Keep for Their Records