Marshall Family Dentistry

Family & Cosmetic Dental Care

We are happy you have chosen our office! Our dental team is here to serve you and provide you with the finest dental care available. As your dental care team, we will do everything in our power to make your experience here a pleasurable one.

Our main goal is to design treatment plans that are convenient, appropriate, and sensitive to your needs. Because research is continually showing a link between oral health and overall health, your preventive oral care appointments are valuable. These cleaning appointments are designed to keep your smile bright and healthy, while minimizing the chances of further dental problems, as we are able to catch potential problems early on.

Our office is available to serve your needs Monday through Thursday between the hours of 8:00am and 5:00pm. Feel free to call us with any questions or problems you may have during these times or you may leave a message after hours. Please note that we are closed on Fridays, however, phones are usually answered until 12:00 noon. We also have an emergency line available only to established patients outside of these hours.

In an effort to handle your care and treatment in an effective and efficient way, we are asking you to honor our 2 business day cancellation policy. Each cancellation is a significant loss to you as the patient, our office, and also our other patients. Please note cancellation fees may apply if this policy is not honored.

We are happy to file your insurance as a courtesy to you, and will do our best to update your coverage based on the information your insurance company provides us. **However, as it is your policy, for the most accurate benefit information, it is your responsibility to contact your insurance company to understand the specifics of your particular plan. Please keep in mind that insurance is available to assist you and you may be required to pay a portion of your visit.** You may ask our staff to discuss your treatment and payment options.

Our primary goal is to make sure that your dental care is not only our top priority, but yours as well. We deeply value you as a patient and want you to feel free to contact us with any questions or concerns.

Welcome to our office!

Dr. Ted Marshall, Dr. Molly Marshall Hays, and Staff

_____

Patient's Signature

MARSHALL FAMILY DENTISTRY
REGISTRATION FORM

(Please print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single/Mar/Div/Sep/Wid

Is this your legal name: ☐ Yes ☐ No	If not, what is your legal name?	(E-mail address):	Birth date: / /	Age:	Sex: ☐M ☐F

Street address:	Social Security #:	Home phone #: ( )

City:	State:	Zip Code:	Preferred Pharmacy:

Occupation:	Employer:	Employer phone #: ( )

Chose this office because/referred by (please check one box):

☐ Family ☐ Friend ☐ Close to home/work

☐ Internet/Google ☐ Insurance ☐ Other

Other family members seen here:

INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

DENTAL HEALTH HISTORY

Reasons for your visit today, and please tell us your concerns:_____
_____
_____
Date of last dental visit _____ Former Dentist_____ Phone (____)_____
How often do you brush? _____ How often do your floss? _____

If you can answer yes, please check any of the following and explain in the space provided:

- ☐ Do your gums bleed while brushing or flossing? _____
- ☐ Are your teeth sensitive to hot or cold fluids/foods? _____
- ☐ Are your teeth sensitive to sweet or sour liquids/foods? ____ _____
- ☐ Do you feel pain in any of your teeth? _____
- ☐ Do you have difficulty controlling bad breath? _____
- ☐ Have you ever been advised you need periodontal treatment? _____
- ☐ Have you had any jaw injuries? _____

Have you experienced any of the following? Please, check the box and explain.

- ☐ Clicking in the jaw _____
- ☐ Pain (joint, side of face) _____
- ☐ Difficulty in opening or closing mouth _____
- ☐ Frequent headaches _____
- ☐ Difficulty with extractions _____
- ☐ Prolonged bleeding _____
- ☐ Orthodontic treatment _____
- ☐ Wearing dentures or partials _____
- ☐ Loose teeth _____
- ☐ Broken fillings or teeth _____
- ☐ Grinding teeth _____
- ☐ Food collecting between teeth _____
- ☐ Oral hygiene instruction/teeth, gums _____

Is there anything you would do to improve the overall appearance of your teeth or smile? _____
_____
Are you interested in whitening your teeth? _____

MEDICAL HEALTH HISTORY

Physician's name _____Office phone (_____)_____Date of last visit_____
If you can answer yes, please check any of the following and explain in the space provided.

- ☐ Are you taking any medications, pills, or drugs?_____
- ☐ Do you require any anti-biotic pre-medication prior to dental work? _____
- ☐ Are you under medical treatment now? _____
- ☐ Within the last 5 year, have you been hospitalized for surgery/illness? _____
- ☐ Have you been told that you snore? _____
- ☐ Do you use tobacco? (please specify form and amount) _____

Please explain any "yes" answers:

_____
_____
Women: Are you…

- ☐ Pregnant/Trying to get pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives

Are you allergic to any of the following? Please check boxes if "yes".

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acryilic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Barbiturates	☐ Iodine	☐ Sedatives	☐ Other _____

Have you experienced any of the following? Please check the box and explain in the space below.

☐ AIDS/HIV Positive	☐ Emphysema	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Epilepsy or Seizures	☐ Pain in Jaw Joints
☐ Anaphylaxis	☐ Excessive Bleeding	☐ Psychiatric Care
☐ Anemia	☐ Fainting Spells/Dizziness	☐ Radiation Treatments
☐ Anorexia/Bulimia	☐ Frequent Cough	☐ Reflux
☐ Anxiety	☐ Glaucoma	☐ Renal Dialysis
☐ Arthritis/Gout	☐ Heart-Irregular Beat/Murmur	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Heart-Angina/Attack	☐ Shingles
☐ Artificial Joint	☐ Heart-Disease/Failure	☐ Sickle Cell Disease
☐ Asthma	☐ Heart –Pacemaker	☐ Sinus Trouble
☐ Blood Clots	☐ Hemophilia	☐ Sjogren's Syndrome
☐ Blood Disease	☐ Hepatitis B	☐ Sleep Apnea
☐ Blood Transfusion	☐ Hepatitis C	☐ Spina Bifida
☐ Breathing Problems	☐ High Blood Pressure	☐ Stomach/Intestinal Disease
☐ Cancer	☐ High Cholesterol	☐ Stroke
☐ Chemical Dependency	☐ Hypoglycemia	☐ Swelling of Limbs
☐ Chemotherapy	☐ Kidney Problems	☐ Thyroid Problems
☐ Chest Pains	☐ Leukemia	☐ Tonsillitis
☐ Cold Sores/Fever Blisters	☐ Liver Disease	☐ Tuberculosis
☐ Cortisone Medicine	☐ Low Blood Pressure	☐ Tumors or Growths
☐ Diabetes	☐ Lung Disease	☐ Ulcers
☐ Drug Addiction	☐ Mitral Valve Prolapse	☐ Venereal Disease

Explain/Other_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform this office if there is a change in my health or that of my children. I certify that I, and /or my dependent(s), have insurance coverage with _____and assign directly to Marshall Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Marshall and Dr. Hays may use my health care information and my disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or two years from the date signed below.

_____ _____

Signature of Patient, Guardian or Personal Representative(or typed if submitted electronically) Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Marshall Family Dentistry

Family & Cosmetic Dental Care

POLICY FOR EXCEPTIONAL CARE AND PAYMENT

Ensuring that our patients receive exceptional care is the goal of our practices.

Payment is due at the time of treatment. This policy allows us to maintain our quality of care. We accept cash, check, and all major credit cards. We also provide payment options through CareCredit and CapitalOne HealthCare. These options allow treatment to begin immediately while allowing you the flexibility of payment plans.

If ***statement billing*** through CareCredit or CapitalOne HealthCare is your choice, we will assist you in completing the process. Applying for CareCredit of CapitalOne HealthCare only takes a few minutes and there is no application fee. Upon approval, payment is made directly to this office from either institution.

For an estimate of monthly payments, please feel free to ask our staff. Remember, we are here to provide you with the finest care and also want to provide a financial plan to meet your needs.

_____ _____

Signature of Responsible Party Date

Marshall Family Dentistry
8830 South Yale Avenue
Tulsa, Oklahoma 74137-3551
918-492-6200

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have received a copy of Marshall Family Dentistry's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other:

_____
_____
_____
_____

MARSHALL FAMILY DENTISTRY

Authorization for Use or Disclosure of Protected Health Information

Patient Name_____ Date of Birth_____

Many of our patients allow an individual such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released, you must sign this form. Signing this form will only give information to the names listed below.

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Information authorized for use or disclosure, or to be obtained:

A. Disclose my complete dental record (including but not limited to diagnoses, treatment, and billing, for all conditions)
B. Form of Disclosure (an electronic record or hard copy)

I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, I would like this permission to be indefinite or until _____(date).

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

Marshall Family Dentistry
8830 South Yale Avenue
Tulsa, Oklahoma 74137-3351
918-492-6200

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by/to anyone outside of our practice. You may gain access to this information if you desire.

Please review it carefully. The privacy of your health information is important to us.

- **Our Legal Duty**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on April 14, 2003 and will remain in effect.

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 make the new notice available upon request.

You may request a copy or our notice at any time. For more information about our privacy practices or for additional copies of this notices, please contact us using the information listed at the end of this notice.

- **Uses and Disclosures of Health Information**

We use and disclose health information about you for treatment, payment, and healthcare operations for example.

Treatment: We may use or disclose your health information to a physician or other healthcare provider who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance conducting training programs, accreditation, certification, licensing or credentialing activities.

- **Your Authorization**

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g., a family member picking up records, referral to a dental specialist, etc.). If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

- **To Your Family and Friends**

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare but only if you agree that we may do so.

- **Persons Involved in Care**

We may use or disclose health information to notify, or assist in the notification of (included 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 of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that 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.

Marketing Health-Relation Services: Our dental office does not use patient information for any marketing purposes. We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when it is required by law to do so (i.e. missing person, etc.)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

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

- **Patient Rights**

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 practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for any purpose, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement except in an emergency.

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

Amendment: You have the right to request that we amend your health information. Your request must be in writing. It must explain why the information should be amended. We may deny your request under certain circumstances.

- **Questions and Complaints:**

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that 1) we may have violated your privacy right, 2) you disagree with a decision we made about access to your health information, 3) in response to a request you made to amend or restrict the use or disclosure of your health information or 4) 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 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.

Contact Officer: **Molly Hays, Privacy Officer**
Ted L. Marshall, D.M.D., Owner

Telephone: **918.492.6200**

Address: **8830 South Yale Avenue**
Tulsa, Oklahoma 74137-3551