WARREN L GOOD, DDS, PC

2112 South Atlanta Place
Tulsa, Oklahoma 74114
918-743-6151

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Dr Warren Good's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Expiration -- 3 Years from Initial Signature; Insurance Change; Patient reaches age of 18

I consent for the office of Dr Warren Good to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ / _____ / _____

_____ / _____ / _____

Signature: _____

☐ Patient ☐ Parent ☐ Guardian / Other

HEALTH HISTORY

WARREN L. GOOD, D.D.S.

Date _____

Name: Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ Age _____ Male _____ Female _____ Single _____ Married _____ Widowed _____

Employer _____ SS # _____ Bus Phone _____

Spouse Name _____ Employer _____ Bus Phone _____

Emergency Contact Name _____ Phone # _____

Person financially responsible _____

Do you have dental insurance? Yes No Insurance Co. _____

Address _____ City _____ State _____ Zip _____

Group/Plan No. _____ Name of Insured _____

SS # _____ Relationship to patient _____

Do you have <u>other</u> dental insurance? Yes No Insurance Co. _____

Address _____ City _____ State _____ Zip _____

Group/Plan No. _____ Name of Insured _____

Whom may we thank for this referral? _____

Are you under the care of a physician?..... Yes No

If yes, please explain _____

_____

Name of physician _____

Are you currently taking anticoagulant medication? ... Yes No

Are you currently taking aspirin?..... Yes No

List medications taken _____

_____

Have you ever responded adversely to dental treatment? Yes No

Do you need to be pre-medicated with antibiotics prior to dental treatment?..... Yes No

Do you or have you ever taken bone loss medications? . Yes No

Do you use tobacco?..... Yes No

Do you like your smile? ..... Yes No

Are you allergic to any of the following?

Y	N	Acrylic	Y	N	Metal
Y	N	Aspirin	Y	N	Penicillin
Y	N	Codeine	Y	N	Sulfa Drugs
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other _____
Y	N	Latex			_____

WOMEN

Are you taking birth control pills? ..... Yes No

Are you pregnant?..... Yes No

Are you nursing?..... Yes No

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

Angina	Y	N	Hepatitis	Y	N
Arthritis	Y	N	High blood pressure	Y	N
Artificial heart valve	Y	N	HIV or AIDS	Y	N
Artificial joints	Y	N	Leukemia	Y	N
Asthma	Y	N	Mitral valve prolapse	Y	N
Cancer	Y	N	Osteoporosis	Y	N
Chemotherapy	Y	N	Radiation treatments	Y	N
Diabetes	Y	N	Rheumatic fever	Y	N
Emphysema	Y	N	Sinus problems	Y	N
Epilepsy or Seizures	Y	N	Stroke	Y	N
Fever blisters	Y	N	Tuberculosis	Y	N
Heart attack	Y	N			

Any symptoms of COVID-19 or contact with anyone who has symptoms? Y N

Any additional health information _____

_____

_____

_____

_____

_____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do authorize the dental staff to perform necessary dental services for my child.

Signed _____ Date _____

I acknowledge that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Signed _____ Date _____