**Drs. Colpitts & O’Brien Wellness Center**

2448 East 81st Street, Suite 1600

Tulsa, OK 74137

**Phone: (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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Major complaint or reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been seen for this condition? Y or N Date: \_\_\_\_\_\_\_\_\_\_ What was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***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 the 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 prolapsed

\_\_\_\_ High blood pressure

\_\_\_\_ Have you been told (by physician) to take an antibiotic prior to dental appointment

\_\_\_\_ 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 **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 medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if lengthy, please provide on separate sheet)

Are you on a detox regimen? Y or N What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other medical conditions not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Share Information**

I consent for Dr. Colpitts and/or Dr. O’Brien to share my personal information, especially with regards to my dental diagnosis and treatment, with the following people and, if applicable, to my dental insurance company.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_