ORIGIN
DENTAL WELLNESS

Date _____-_____-_____

Please Print

general information

PATIENT NAME Last _____ First _____ Nickname_____

DATE OF BIRTH _____-_____-_____ ☐ MALE ☐ FEMALE ☐ Married ☐ Single ☐ Child

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE Home _____ Work _____ Cell _____

EMAIL _____ How do you prefer to be contacted? ☐ Email ☐ Phone: ___home ___work ___ cell ___

EMPLOYER INFORMATION _____

SSN (for insurance purposes) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ LICENSE NUMBER _____

EMERGENCY CONTACT **1**: NAME _____Relationship to you _____ Phone _____

EMERGENCY CONTACT**2**: NAME _____ Relationship to you _____ Phone _____

INSURED OR RESPONSIBLE PARTY INFORMATION:

NAME _____ Is insured an existing patient? ☐ Yes ☐ No Relationship to Patient _____

ADDRESS_____

PHONE H) _____ W) _____ C) _____

DATE OF BIRTH _____ SSN (insurance purposes) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

INSURED EMPLOYER NAME_____ EMPLOYER PHONE _____

EMPLOYER ADDRESS _____

INSURANCE PLAN NAME _____ ID# _____GROUP # _____

ADDRESS _____ PHONE_____

Please Print

medical information

DO YOU HAVE OR HAVE YOU EVER HAD:

☐ Allergic reaction to:

___ aspirin, ibuprofen or acetaminophen
___ penicillin
___ erythromycin
___ tetracycline
___ codeine
___ local anesthetic
___ fluoride
___ metals (gold, nickel)
___ latex
___ other _____

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Blood Pressure: __ High __ Low
☐ Cancer: _____
☐ __ Radiation __ Chemotherapy
☐ Cyst or abnormal growth
☐ Diabetes
☐ Depression
☐ Digestive Disorders
☐ Dizziness
☐ Epilepsy/Seizures
☐ Fainting
☐ Glaucoma
☐ Head Injury
☐ Heart Disease
☐ Hepatitis
☐ HIV/AIDS
☐ Hives or skin rash
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental or Nervous Disorders
☐ Osteoporosis, Osteopenia, Paget's Disease
☐ Medications_____
☐ Pacemaker
☐ Respiratory: ____ COPD ____ Emphysema
☐ Sinus Problems
☐ STD
☐ Stomach Problems/Acid Reflux
☐ Stroke
☐ Thyroid or Parathyroid Disease
☐ Tuberculosis

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
FEMALES: ARE YOU PREGNANT OR MIGHT YOU BE? ☐ YES Due Date _____ ☐ NO
DO YOU USE TOBACCO? ☐ YES what type? _____ how much or how often _____ ☐ NO
LIST ANY MEDICATIONS, HERBAL SUPPLEMENTS, AND/OR VITAMINS YOU ARE TAKING: _____

_____
_____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING SURGERY, OR OTHER HEALTH ISSUES YOU CURRENTLY HAVE:
_____
_____
_____
_____

Please Print

dental history

REFERRED BY .....

HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PREVIOUS DENTIST ..... HOW LONG WERE YOU A PATIENT? ..... Months / Years

MOST RECENT: DENTAL EXAM ...../...../..... X-RAYS ...../...../..... TREATMENT (other than cleaning) ...../...../.....

HOW OFTEN DO YOU SEE YOUR DENTIST? Every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? .....

PLEASE ANSWER YES OR NO TO EACH OF THE FOLLOWING QUESTIONS:

PERSONAL HISTORY	**YES**	**NO**
1. Are you fearful of dental treatment? If yes, rate on a scale of 1-10 (ten being very fearful): _____ - - -	○	○
2. Have you had an unfavorable dental experience? -	○	○
3. Have you ever had complications from past dental treatment? -	○	○
4. Have you ever had trouble getting numb or had reactions to local anesthetic? - - - - - - - - - - - - - - - - -	○	○
5. Did you ever have braces, orthodontic treatment or your bite adjusted? -	○	○
6. Have you had any teeth removed? -	○	○

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? ○ ○
8. Have you ever whitened (bleached) your teeth? ○ ○
9. Are you self-conscious about your teeth? ○ ○
10. Have you been disappointed with the appearance of previous dental work? ○ ○

BITE & JAW JOINT

11. Do you have any problems chewing gum? ○ ○
12. Do you have any problems chewing bagels or other hard foods? ○ ○
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ○ ○
14. Are your teeth crowding or developing spaces? ○ ○
15. Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together? ○ ○
16. Do you have any problems with sleep in general, or wake up with an awareness of your teeth? ○ ○
17. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? ○ ○
18. Do you have tension headaches or sore teeth? ○ ○
19. Do you wear, or have you ever worn a bite appliances? ○ ○

TOOTH STRUCTURE

	YES	NO
20. Have you had any cavities in the past 3 years?	○	○
21. Do you have a dry mouth?	○	○
22. Are any teeth sensitive to hot, cold, biting or sweets?	○	○
23. Have you ever had a toothache, cracked filling, or a broken, chipped or cracked tooth?	○	○
24. Do you avoid brushing any part of your mouth?	○	○
25. Do you feel or notice any holes (pitting) in your teeth?	○	○

GUM & BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? ○ ○
27. Have you ever experienced gum recession? ○ ○
28. Is there anyone with a history of periodontal disease in your family? ○ ○
29. Do your gums bleed when brushing, flossing or eating? ○ ○
30. Are your teeth becoming loose? ○ ○
31. Have you ever noticed an unpleasant taste or odor in your mouth? ○ ○
32. Have you experienced a burning sensation in your mouth? ○ ○

I consent to dental and oral surgical procedures deemed necessary or advisable, including the use of local anesthetic; I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing Dr. Toler of any changes to my health at my next appointment.

PATIENT SIGNATURE _____ DATE _____ DOCTOR SIGNATURE _____ DATE _____

shannon k toler / dds
2100 S Utica, Suite 205
tulsa ok 74114
918.747.6453
www.origindentalwellness.com

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who have a dental insurance plan, understand that **all dental services furnished are charged directly to the patient and the patient or responsible party is personally responsible for payment of all dental services.** This office will prepare patient insurance forms and assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the treatment investment and the fee listed for this dental care can only be extended for a period of 90 days from the date of the patient planning appointment. If the patient doesn't have a planning appointment, this courtesy will be extended for the same 90 day period from the date of the initial exam.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the Doctors reasonable fee of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable fee of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I authorize this office to use my name (in complete or edited form), photograph(s), or other images as may be necessary of me (i.e. radiographs and digital photos), with or without my given name and city for advertising, education or any other lawful purpose and I release and forever discharge said Doctor from any claim, demands or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

I have read the above conditions of treatment and payment and agree to their content.

_____

Patient, Parent or Guardian Signature Date

_____ _____

Patient Name (Please Print) Additional Patient Names (if minors)

Current Financial Policy

Thank you for choosing Origin Dental Wellness. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment options you can choose from:

- Cash or Check
- Visa, MasterCard, Discover and American Express
- Financing available for those who qualify

Please note:
Origin Dental Wellness, PLLC requires payment at the time of your appointment. In isolated cases we may require a non-refundable deposit in order to schedule your appointment.

As a courtesy to you, we will file your insurance claims and do our best to maximize your benefits. Financially, our relationship is with you and not your insurance company. We ask that you take care of your estimated portion of payment at the time services are provided. Should your insurance company send payment to you directly, we expect that payment be forwarded to our office. Any communication between our office and your insurance company is not a guarantee of payment; it is a courtesy to you, our patient. Because we provide dental care, not insurance benefits, you are responsible for any service fees not paid for by your insurance company.

We reserve the right to charge $75.00 per scheduled hour if a 48 hour notice is not given to cancel the appointment.

Origin Dental Wellness, PLLC charges $35.00 for returned checks in addition to any charges from our bank.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I acknowledge that I understand these financial parameters.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Effective date of notice: October 25, 2018

NOTICE OF PRIVACY PRACTICES

Origin Dental Wellness
Shannon K. Toler, DDS
2100 S Utica #205
Tulsa, OK 74114
918-747-6453

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations: mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission. We will ask for special written permission in the following situations: transfer of records to another provider, or anyone other than the patient is picking up records from our office for transfer.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses or disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office address shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance.

If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office address shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office address, shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office address, shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office address, shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Shannon K. Toler, DDS, PLLC Notice of Privacy Practices.

Patient name_____

Signature_____ Date_____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (e.g. theater, meeting, lecture)	
As a passenger in a car for an hour w/out a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

Compliments of:
Shannon K Toler, DDS
2100 S Utica #205
Tulsa, OK 74114
918.747.6453 (918.74.SMILE)
www.origindentalwellness.com