CLIFFORD
FAMILY DENTISTRY

PATIENT INFORMATION

Date:_____
ID#/SSN#: _____

Patient: _____
Address: _____
_____
City State Zip
Sex: ❑ M ❑ F Age: _____ Birthdate:
_____
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Email: _____
Occupation: _____
Employer: _____
Address: _____
Phone: _____

Spouse's Information
Name: _____
Birthdate: _____ SSN#: _____
Occupation: _____
Employer: _____
Who may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient: _____
Insurance Co: _____
Group #: _____
Is patient covered by additional insurance? ❑ Yes ❑ No
Subscriber's Name: _____
Birthdate: _____ SSN#: _____
Relationship to Patient: _____
Insurance Co: _____
Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Nick Clifford 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

PHONE NUMBERS

Home: _____ Work: _____ Etx_____ Cell: _____
Best time and place to reach you: _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
Name: _____ Relationship: _____
Home: _____ Work: _____ Etx_____ Cell: _____

DENTAL HISTORY

Reason for today's visit: _____
_____
Former Dentist: _____
City/State: _____
Date of last dental visit: _____
Date of last dental x-rays: _____

Check if you have any of the following:
- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Cigarette, pipe, or cigar smoking
- ❑ Clicking or popping jaw
- ❑ Dry mouth
- ❑ Fingernail biting
- ❑ Food collection between the teeth
- ❑ Foreign objects
- ❑ Grinding teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain or tiredness
- ❑ Lip or cheek biting
- ❑ Loose teeth or broken fillings
- ❑ Mouth breathing
- ❑ Mouth pain, brushing
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss? _____
How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (lenfluramine) and Redux (dexfenfluramine). ❑ Yes ❑ No

Check if you have any of the following:

❑ AIDS/HIV
❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ Back Problems
❑ Bleeding abnormally, w/extractions or surgery
❑ Blood Disease
❑ Cancer
❑ Chemical Dependency
❑ Chemotheraphy
❑ Circulatory Problems
❑ Congenital Heart Lesions
❑ Cortisone Treatments
❑ Cough, persistent or bloody
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fainting or dizziness
❑ Glaucoma
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
❑ Hepatitis Type _____
❑ Herpes
❑ High Blood Pressure
❑ Jaundice
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Low Blood Pressure
❑ Mitral Valve Prolapse
❑ Nervous Problems
❑ Pacemaker
❑ Psychiatric Care
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Sinus Trouble
❑ Skin Rash
❑ Stroke
❑ Swelling of Feet/Ankles
❑ Swollen Neck Glands
❑ Thyroid Problems
❑ Tonsillitis
❑ Tuberculosis
❑ Tumor or growth on head/neck
❑ Ulcer
❑ Venereal Disease
❑ Weight Loss, unexplained

Do you wear contact lenses? ❑ Yes ❑ No

Women:
Are you pregnant? ❑ Yes ❑ No Due date: _____

Are you nursing?
❑ Yes ❑ No

Taking birth control pills?
❑ Yes ❑ No

MEDICATIONS

List any medications you are currently taking and the corresponding diagnosis:

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

❑ Aspirin
❑ Barbiturates (sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____

_____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last appointment? ❑ Yes ❑ No
For what conditions? _____
Are you taking any new medications? _____

_____ _____ _____ _____
Patient's Signature Date Doctor's Signature Date

Has there been any change in your health since your last appointment? ❑ Yes ❑ No
For what conditions? _____
Are you taking any new medications? _____

_____ _____ _____ _____
Patient's Signature Date Doctor's Signature Date

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. **Individual Information** (For person whose information will be shared)

_____ _____
Name Date of birth

_____ _____
Address City, State Zip

_____
Area Code & Phone Number

I. **Scope and Purpose for Sharing**
I understand protected health information is information that identifies me. The purpose of this authorization is to allow Nicklaus P. Clifford, DDS to share my protected health information.

II. **I authorize Nicklaus P. Clifford, DDS as set forth below, to share my protected information for reasons in addition to those already permitted by law.**

A. **Persons/Organizations Authorized to Receive My Information**

_____ _____
Name, Address, Phone/Fax Relationship/Purpose

_____ _____
Name, Address, Phone/Fax Relationship/Purpose

_____ _____
Name, Address, Phone/Fax Relationship/Purpose

B. **Information to be Shared:**

1. Check one or more boxes below.
   - ❑ Diagnosis
   - ❑ Entire Dental Records
   - ❑ Pathology Reports
   - ❑ Progress Notes
   - ❑ Radiographs
   - ❑ Treatment
   - ❑ Treatment Plans
   - ❑ Other _____

2. Covering services between _____ and _____ (insert date(s) or "all").

HIPAA Document - retain a minimum of three years.

III. **Expiration & Revocation**

A. **This Authorization will Expire** (must choose one):
   - ❑ 3 years after last office encounter
   - ❑ Other (insert date or event): _____

B. **Right to Revoke**
I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

IV. Acknowledgements & Signatures

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
2. I understand if the persons/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.
3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of this form.
4. I understand Nicklaus P. Clifford, DDS may utilize an electronic network to exchange my protected health information with other providers unless I choose not to participate.
5. I acknowledge information authorized for release my include records which may indicate the presence of a communicable or non-communicable disease.

B. Signature

This document must be signed by the individual or the individual's representative.

_____

Signature (Patient or Legal Representative)

_____ _____

Printed Patient or Legal Representative Name Capacity of Legal Representative

Physician/Clinic Address: Clifford Family Dentistry
801 24th Ave NW
Norman, OK 73069