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 ❑ Radiographs
   - ❑ Entire Dental Records ❑ Treatment
   - ❑ Pathology Reports ❑ Treatment Plans
   - ❑ Progress Notes ❑ 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
808 24th Ave NW #101
Norman, OK 73069