FAMILY DENTISTRY
Rachel Standlee, DDS

Patient Information

Name _____

Birth Date: _____ SSN: _____

Address _____

City/State/Zip_____

Telephone: _____Email: _____

Primary Dental Insurance Co. _____

Group #_____ SSN/ ID #:_____

Employer: _____

Subscriber Name: _____ Birth Date:_____

Secondary Insurance Co. _____

Group #_____ SSN/ ID #:_____

Employer: _____

Subscriber Name: _____ Birth Date:_____

Whom may we thank for referring you to our office?

_____

Dental History

Please check any of the following problems that apply to you

- ☐ Sensitivity (hot, cold, sweet, pressure) where? UR LR UL LL
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Bad breath

Do you or have you ever had the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Do you smoke or use chewing tobacco?
How much? _____
For how long? _____

If you could change your smile, would you:

- ☐ Make it whiter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Repair chipped teeth
- ☐ Replace missing teeth

Please share the following dates:

Your last dental checkup:

_____

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

When receiving information, do you like the details or the bottom line?

_____

Medical History

Please check any of the following conditions that apply to you:

- ☐ AIDS
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions (congenital)
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High/Low Blood Pressure
- ☐ HIV Positive
- ☐ HPV (human papilloma virus)
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Pregnant Currently
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases
- ☐ Mentally/Physically Disabled
- ☐ Other

_____

_____

_____

_____

Are you allergic or have you reacted adversely to any of the following medications?

- ☐ Aspirin
- ☐ Darvon
- ☐ Nitrous Oxide
- ☐ Percodan
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Tetracycline
- ☐ Codeine
- ☐ Erythromycin
- ☐ Valium
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

Have you ever taken any of the following medications?

- ☐ Actonel
- ☐ Aredia
- ☐ Fosamax
- ☐ Reclast
- ☐ Zometa
- ☐ Boniva
- ☐ Herbal
- ☐ Supplements

Are you under a physician's care? For?

_____

What Medications are you currently taking?

_____

_____

Family Physician/phone number

_____

To the best of your knowledge, all the previous answers are correct. If I have any changes in my health I will inform the dentist and staff at the next appointment

X _____

Date: _____

FAMILY DENTISTRY
Rachel L. Standlee, DDS

OUR COMMITMENT:

At Family Dentistry, we are committed to excellence! Serving you through dentistry is our pleasure and you deserve nothing less than excellence when it comes to your health. We use the highest quality materials and most proven techniques available to provide you with the exceptional quality you should expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We take pride in communicating all of your dental needs and estimating your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is and we will make every effort to remain on time for your reserved appointment time. We do not double book our appointed reservations for patients. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

YOUR COMMITMENT:

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial concerns, or any others, we ask you to please notify us as soon as possible. We will joyfully clarify any uncertainties that may arise.

Your payment portion of any treatment received is expected at the time of service. For your convenience, we do accept many forms of payment including interest free programs and extended financing.

Your scheduled appointment is reserved exclusively for you. We have a 48-hour cancellation policy to provide you with personalized attention and care. We understand that circumstances may arise that require a reservation to be rescheduled. We are happy to change your reservation time if a 48-hour notice is received. If sufficient notice is not given, your account will be charged a $50 missed reservation fee. We ask that you please make every effort to maintain your appointed time and we look forward to serving you with our utmost respect and exceptional care!

Patient/Guardian Signature: _____

Date: _____

(918) 299.7750 (918) 296.9717
7707 East 111th Street ♥ Suite #105 ♥ Tulsa, OK ♥ 74133

FAMILY DENTISTRY
Rachel Standlee, DDS

RACHEL L. STANDLEE, D.D.S., PLLC & LAUREN NICHOLS, D.D.S.
7707 East 111TH STREET, Suite 105, Tulsa, OK 74133 (918) 299.7750

Date: _____

Signature: _____

I consent for the office of Drs. Rachel L. Standlee and Lauren Nichols to share my personal information with the following: (family, friends, etc.)

Name / Relationship:

1. _____ / _____
2. _____ / _____
3. _____ / _____
4. _____ / _____
5. _____ / _____
6. _____ / _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have been offered and/or received a copy of Dr. Rachel L. Standlee's & Dr. Lauren Nichols' 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 parties. I understand that I may request a copy of the privacy policies at any time.

_____
Please Print Patient Name

_____
Patient/Parent/Guardian Signature

_____
Date