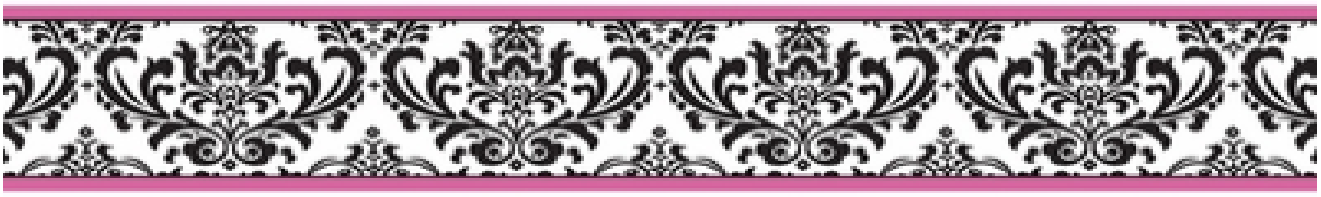

Leslie Tevebaugh D.D.S.
1722 Main Street - Woodward, OK
(580) 256-6816

Patient Information:

Patient Name: _____ Preferred Name: _____
Birth Date: _____ Male: _____ Female: _____ Single: _____Married:_____
SS#: _____
Address: _____ City: _____
State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
E-Mail Address: _____
Employer: _____
Emergency Contact: _____ Relationship: _____
Phone Number: _____
Other family members seen by us: _____

Parent/ Guardian Information:

Name: _____ Relationship to patient: _____
Birth Date: _____ SS#: _____
Address: _____ City: _____ State: _____
Zip: _____ Employer: _____ Work Phone: _____
Home Phone: _____ Cell Phone: _____

Dental Insurance Information (Primary):

Policy Holder's Name: _____ Birth Date: _____
SS#:_____ Insurance Company: _____ Group #:_____
Employer: _____ Policy Holder's ID#: _____
Patient Relationship to Policy Holder: _____

Dental Insurance Information (Secondary):

Policy Holder's Name: _____ Birth Date: _____
SS#:_____ Insurance Company: _____ Group #:_____
Employer: _____ Policy Holder's ID#: _____
Patient Relationship to Policy Holder: _____

Time 11:02 AM | LESLIE A. TEVEBAUGH, D.D.S. | Date 2/15/2019

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

PATIENT CONSENT FORM

I understand, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health/dental information. I understand this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly and/or indirectly
2. Conduct normal healthcare operations, such as physician certifications and assessments.
3. Obtain payment from third party payers, such as insurance companies.
4. Confirm and leave messages at phone numbers provided to this office

I have been informed of your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Privacy Practices

I understand that I may requests in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or dental care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient:_____

Additional family members granted access:

_____

Signature: _____Date_____

Failed Appointments:

We consider ANY appointment we make to be a strong commitment. We ask that you do not miss your confirmed appointment or there will be a $50 charge to your account.

Patients that continually miss appointments will lose the privilege to schedule future appointments with our office and will ONLY be called on short notice.

Thank you for your cooperation,

Dr. Leslie Tevebaugh DDS and staff

What do you do on a daily basis to take care of your teeth and gums?

Do your now have or have you ever experienced pain/discomfort in your jaw (TMJ)? YES/NO

Do you snore? YES/NO

Have you been diagnosed with Obstructive Sleep Apnea? YES/NO

If yes, do you wear a CPAP? YES/NO

If yes, are you compliant? YES/NO

Has anyone ever told you that you stop breathing in the night? YES/NO

On a scale of 1 to 5, 1 being the worst 5 being the best) how well do you think you sleep? 1 2 3 4 5

Have you had your tonsils and adenoids removed? YES/NO

FINANCIAL AGREEMENT

PAYMENT IS DUE AT THE TIME SERVICES ARE PERFORMED

___ I have Delta Dental Premier or other insurance and will pay my estimated portion today.

We are only a participating provider for Delta Dental Premier of Oklahoma. Your estimated portion is due on or before the date of service. We suggest contacting your insurance company to obtain specific information about your policy such as waiting periods, yearly maximums, etc.

___ I DO NOT have dental insurance and will be paying in full for treatment at the time of service.

Your estimated portion is only an estimate. We will allow your insurance 45 days to pay. After the 45 days, whether the insurance has paid or not, any remaining balance is the responsibility of the patient or responsible party.

For patients with insurance: by signing below, I authorize my insurance to pay Leslie A. Tevebaugh, DDS directly for benefits otherwise payable to me.

I HAVE READ AND UNDERSTAND THE FINANCIAL INFORMATIONTHT HAS BEEN PROVIDED FOR ME.

_____ _____

Signature Date