Dr. Danny P. O'Keefe, DDS
996 Top Street
Flowood, MS 39232

Patient Information

Patient Name: _____Date:_____

Street Address: _____

City: _____State: _____Zip:_____

Social Security #:_____Birth Date: _____

Phone Numbers: Home: _____Work:_____ Cell: _____

Employer: _____ Occupation: _____How Long: _____

Marital Status: _____Married _____Single _____Widowed _____ Divorced Spouse Name_____

Email address: _____
Referred by: _____

Hobbies/Interests: _____

Financial Responsibility

Responsible Party for this Account: _____

Address:
_____

Employer: _____Work Phone: _____

Responsible Party SS# _____Relationship to Patient:
_____

Dental Insurance Information

Insurance Company: _____

Mailing Address: _____

City: _____

State: _____Zip: _____

Name of Insured: _____

Insured's Date of Birth: _____

Insured's Social Security #:_____

Relationship to patient: _____

If you have a secondary insurance, we will be glad to file it for you, however, we do not accept it as your payment.

For the Record (in the event of emergency, who should we contact?)

Name: _____ Relationship: _____

Phone Numbers:
Home_____Work:_____Cell:_____

Medical History

Are you under the care of a Medical Physician? ……YES……..NO

Name of Medical Physician: _____

Date of Last Physical Exam_____

Has there been any change in your general health within the past year? .....YES……NO

Have you had a serious illness or operation …….....YES……NO

If yes, give date and explain_____

Have you ever required a blood transfusion? .....YES……NO

If yes, give date_____

Are you employed in any situation which exposes you regularly to x-rays of other ionizing radiation? ……YES……NO

Have you had surgery, x-ray or drug treatment for a tumor, growth or other condition of your head or neck YES……NO

HAVE YOU EVER HAD ANY THE FOLLOWING DISEASES, MEDICAL PROBLEMS OR TREATMENTS

Heart Attack	_____Y_____N	Psychiatric problems	_____Y_____N
Stroke	_____Y_____N	Epilepsy	_____Y_____N
Cancer	_____Y_____N	Seizures	_____Y_____N
Chemotherapy	_____Y_____N	Diabetes	_____Y_____N
Rheumatic Heart Disease	_____Y_____N	Tuberculosis	_____Y_____N
Artificial Valves	_____Y_____N	HIV / AIDS	_____Y_____N
Heart Murmur	_____Y_____N	Venereal Disease	_____Y_____N
Congenital Heart Defect	_____Y_____N	Drug / Alcohol Abuse	_____Y_____N
Heart Surgery	_____Y_____N	Stomach Ulcers/ Colitis	_____Y_____N
Pacemaker	_____Y_____N	Hemophilia	_____Y_____N
High Blood Pressure	_____Y_____N	Radiation Therapy	_____Y_____N
Low Blood Pressure	_____Y_____N	Asthma	_____Y_____N
Mitral Valve Prolapse	_____Y_____N	Sinus Problems	_____Y_____N
Kidney Problems	_____Y_____N	Shingles/ Skin Rash	_____Y_____N
Artificial Bones/ Joints	_____Y_____N	Glaucoma	_____Y_____N
Hepatitis/ Liver Disease	_____Y_____N	Inflammatory Rheumatism	_____Y_____N
Fever Blisters/ Sores	_____Y_____N	Emphysema	_____Y_____N
Severe or Frequent Headaches	_____Y_____N	Allergies	_____Y_____N

List of current medications:

_____
_

List other medical/special needs not listed above:

_____
_____
_____
____

Are You Allergic To Any Of The Following?

Local Anesthetics	_____Y_____N	Latex	_____Y_____N
Dental Anesthetics	_____Y_____N	Aspirin	_____Y_____N
Penicillin	_____Y_____N	Tylenol	_____Y_____N
Tetracycline	_____Y_____N	Codeine	_____Y_____N
Erythromycin	_____Y_____N	Other Narcotics	_____Y_____N
Sulfa Drugs	_____Y_____N	Sedatives	_____Y_____N
Iodine	_____Y_____N		

Other? PLEASE LIST
_____
_

Women:

Are you Pregnant? _____Y_____N IF yes, Due Date: _____

Are you nursing? _____Y_____N Are you taking oral contraceptive? _____Y_____N

Do you have any other medical condition not listed above that we should know about? _____
_____
_____
—

Dental History:

Why have you come to the dentist today? _____

Are you currently in pain? _____Y_____N Do your gums ever bleed? _____Y_____ N

Date of Last Dental Visit? _____ what did you have done? _____

Your general dental health is _____GOOD _____FAIR _____POOR

Do you have missing teeth? _____Y_____N Are you wearing removable dental appliances? _____Y_____N

Do you have or have you ever had any pain or discomfort in your jaw (TMD) _____Y_____N

Do you experience migraine headaches? _____Y_____N

Have you ever had any serious problems associated with any previous dental work? _____Y_____N

If yes, please explain
_____
_____
—

DO YOU EXPERIENCE ANY OF THE FOLLOWING:

_____ Frequent, heavy snoring? _____ Significant daytime drowsiness?

_____ Have you been told you stop breathing while sleeping? _____ Gasp at times when waking up?

_____ Feel unrefreshed in the morning? _____ Have morning headaches?

_____ Aware of any teeth grinding at night? _____Often experience nasal congestions?

What is your usual bedtime? _____Wake time? _____ Do you wear a CPAP? _____If so, when did you start wearing it?
_____

How would you describe your level of comfort in the dental office? Please circle one.

Very Comfortable 1 2 3 4 5 Very Anxious

Signature of Dentist _____Signature of Patient_____

FINANCIAL RESPONSIBILITY

You are responsible for all billed procedures while being cared for in our office.

We file insurance claims for you as a courtesy. We are not under any contract with any insurance Companies and are considered an out-of-network provider, therefore your out-of-pocket expenses may be more than with a network provider.

We verify coverage in advance of your appointment. If you are being seen today and we have not had adequate time to verify coverage and/or we do not have a copy of your dental plan card with proper identification, **YOU** will be responsible for paying in full for your charges today.

While we try to get the most accurate information from your insurance carrier, we are not responsible for omissions in coverage not revealed to us. We **recommend** you contact your insurance carrier regarding your dental benefits so that you are informed about what they will and will not cover, as you will be responsible for any balance not paid by them. Plans can change and we are not always made aware of changes until a claim has been filed and processed. When you receive an explanation of benefits from your insurance concerning a procedure performed in our office, please examine it carefully in case the claim has been processed incorrectly. Insurance companies randomly deny claims as a stall tactic and will only pay them if they are challenged.

We create an individual treatment plan and financial agreement with you based on the dental procedures that need to be performed. When signing this agreement, you are signing a contract with us to pay for services provided, regardless of insurance benefits. While we *estimate* what your insurance will pay to the best of our ability that is not a guarantee of what they will pay for any given procedure. They pay based on what they deem is usual and customary when the claim is processed. We do feel like we have a very experienced insurance claims process and do follow-up on unpaid and/or pending claims. If a claim is not paid in 60 days, you will be contacted by our office and expected to pay the bill in full and seek reimbursement from your insurance company.

If you have any questions regarding the above stated policies, please ask our insurance coordinator before the exam.

I have read the above statement and agree to follow these financial guidelines.

NAME: _____DATE:_____