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

Stroke _____Y_____N

Cancer _____Y_____N

Chemotherapy _____Y_____N

Rheumatic Heart Disease _____Y_____N

Artificial Valves _____Y_____N

Heart Murmur _____Y_____N

Congenital Heart Defect _____Y_____N

Heart Surgery _____Y_____N

Pacemaker _____Y_____N

High Blood Pressure _____Y_____N

Low Blood Pressure _____Y_____N

Mitral Valve Prolapse _____Y_____N

Kidney Problems _____Y_____N

Artificial Bones/ Joints _____Y_____N

Hepatitis/ Liver Disease _____Y_____N

Fever Blisters/ Sores _____Y_____N

Severe or Frequent Headaches _____Y_____N

Psychiatric problems ______Y______N

Epilepsy ______Y______N

Seizures ______Y______N

Diabetes ______Y______N

Tuberculosis ______Y______N

HIV / AIDS ______Y______N

Venereal Disease ______Y______N

Drug / Alcohol Abuse ______Y______N

Stomach Ulcers/ Colitis ______Y______N

Hemophilia ______Y______N

Radiation Therapy ______Y______N

Asthma ______Y______N

Sinus Problems ______Y______N

Shingles/ Skin Rash ______Y______N

Glaucoma ______Y______N

Inflammatory Rheumatism ______Y______N

Emphysema ______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

Dental Anesthetics ________Y________N

Penicillin ________Y________N

Tetracycline ________Y________N

Erythromycin ________Y________N

Sulfa Drugs ________Y________N

Iodine ________Y________N

Latex _______Y_______N

Aspirin _______Y_______N

Tylenol _______Y_______N

Codeine _______Y_______N

Other Narcotics _______Y_______N

Sedatives _______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?

________ Have you been told you stop breathing while sleeping?

________ Feel unrefreshed in the morning?

________ Aware of any teeth grinding at night?

_________ Significant daytime drowsiness?

_________ Gasp at times when waking up?

_________ Have morning headaches?

_________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:_____________________________