RIGGS
COSMETIC & FAMILY DENTISTRY

FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your dental health care provider. The following is a description of our policy:

Payment for service is due at the time service is rendered.
We accept cash, check, Visa, MasterCard, Discover, & American Express.
We also offer financing through CareCredit.

As a courtesy to our patients we offer a saving for services over $300.00 when prepaid at least two days prior to appointment.
5% with Cash or Check
Does not apply with CareCredit or Credit Card

All charges are your responsibility whether the insurance company pays or not. Not all services are a covered benefit. Benefits may vary on different insurance plans. Fee for non-covered services, deductibles, and co-payment are due at the time of appointment.

A 24 hour cancellation notice prior to appointment is required. Appointments not kept or cancelled on the same day will be charged a $25.00 per scheduled hour.

I HAVE READ THE ABOVE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____
Signature of Responsible Party Date

_____
Patient Name

DOUG RIGGS, D.D.S.
1025 E. Vandament, Suite 300 • Yukon, OK 73099 • 405.354.1861 • Fax: 405.354.8738

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

I authorize _____(healthcare provider) to use and disclose the protected health information described below to

1 _____

2 _____

3 _____

(individual seeking the information)

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of drug abuse). This includes all past, present, and future periods.

This medical information may be used by the person or persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient

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Patient Text Message/ Email Consent Form

Patient Name: _____

Cell Phone: _____

Email: _____

I hereby give my consent to Dr. Riggs & Bockus Cosmetic & Family Dentistry to call, text, leave a voice message on my cell phone, or email me regarding:

- Appointments
- Treatment
- Insurance
- Personal or family accounts
- Post-op calls

Should I not be able to keep an appointment I will call the office to cancel.

Signature:_____ Date: _____

All patients can opt out of this service at any time by speaking to one of our staff members. Please update our records if you change your mobile number.

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Doug Riggs, D.D.S.

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	Sleep Apnea ◯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:_____

DR. RIGGS FAMILY DENTISTRY

DATE:_____

PATIENT INFORMATION

Name:_____ DOB:_____AGE:____ SSN:_____

Address:_____City, State, Zip_____

Home Phone:_____Cellular Phone:_____Work Phone:_____

E-mail:_____ Sex: oMale oFemale Marital Status: oMarried oSingle oDivorced oWidowed

Employer:_____ Employer Address:_____

EMERGENCY CONTACT: Name:_____Phone:_____

RESPONSIBLE PARTY INFORMATION

Name:_____ Relationship to Patient:_____

Address:_____ City, State, Zip:_____

Home Phone:_____Cellular Phone:_____Work Phone:_____

SSN:_____DOB:_____Employer:_____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Insured:_____ Relationship to Insured: oSelf oSpouse oChild oOther

Insured SSN:_____DOB:_____Employer:_____

Insurance Company:_____ID#_____Group#_____

SECONDARY INSURANCE INFORMATION

Name of Insured:_____ Relationship to Insured: oSelf oSpouse oChild oOther

Insured SSN:_____DOB:_____Employer:_____

Insurance Company:_____ID#_____Group#_____

DENTAL HISTORY

Reason for today's visit:_____

Former Dentist:_____City/State:_____

Date of last dental visit:_____Date of last dental x-rays:_____

Do you have or have you had, any of the following? (Check all that apply)

oBad Breath	oFingernail Biting	oLoose Teeth/Broken Fillings	oSensitivity to Hot/Cold
oBleeding Gums	oFood Collection Between Teeth	oMouth Breathing	oSensitivity When Biting
oBlisters/Cold Sores	oForeign Objects	oMouth Pain when Brushing	oSores/Growths in Mouth
oBotox or Fillers	oGrinding Teeth	oOrthodontic Treatment	oSwollen/Tender Gums
oClicking or Popping Jaw	oJaw Pain/Tiredness	oPain around Ear	oTobacco Use
oDry Mouth	oLip/Cheek/Mouth Biting	oPeriodontal Treatment	oWisdom Teeth Extracted

How often do you Brush?_____Floss?_____ Other Concerns:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____