RAY A BEDDOE, D.M.D., PHARM.D., M.S.
Diplomate of the American Board of Periodontology
PRACTICE LIMITED TO PERIODONTICS and DENTAL IMPLANTS
2619 S. Elm Place, Suite A Broken Arrow, Oklahoma 74012
Tel (918)451-2717 (800)443-2717 Fax (918)455-1491

Patient Information: Please completely answer the following information.

Name: ____ Date: _____________
First Middle Last
Male Female Single Married, Spouse ___________ Other Minor, Parents _________
Patient's SSN: _________________ Birthdate: ___________ Employer: _________________
Patient's Address: ____ _____________
Street Apartment #
City: ______________________________State: _________ Zip: ____________
Home Phone: ______________ Work Phone: _______________ Cell Phone: ____________
E-mail address: ____

Person Responsible for Account: Patient Mother/Father Spouse
Name: ___________________________________ SSN: ________________________
Birthdate: __________________ Employer: _____________________________________
Address: ____________________________ City, State, Zip: _______________________
Home Phone: ______________ Work Phone: _______________ Cell Phone: ____________
E-mail address: ____

Insurance Information: Please completely answer the following information.

Primary Dental Insurance:
Patient Spouse Other
Name: ____________________________
First Middle Last
SSN: _________________ DOB: _______
Employer: __________________________
Insurance Co: ________________________
Group # _________ ID # ______________

Secondary Dental Insurance:
Patient Spouse Other
Name: ____________________________
First Middle Last
SSN: _________________ DOB: _______
Employer: __________________________
Insurance Co: ________________________
Group # _________ ID # ______________

Initial the following:
I authorize:
______ Administration of medications, images and treatment for my periodontal care.
______ Insurance payments made directly to Dr. Beddoe (I am responsible for the remaining balance).
______ I understand that I am responsible for collection charges (30%-50% of the outstanding balance) involved for non-payment on my account.

Signature: ____ **Date**: _____________

Medical History

General Dentist/Referred By: ____

Primary Medical Doctor: ___________________________________ Phone: _____________________________

Preferred Pharmacy : ____________________________ **Pharmacy Location: ______________________________**

Do you have or have you ever had any of the following conditions: (Please Circle All That Apply)

Blood thinners
Abnormal Bleeding/Prolonged bleeding
Anemia / Blood Disorders
Hemophilia
Asthma
Arthritis / Rheumatism
Artificial Joints: __________
Chest Pain
Heart Attack- Date _____________
Heart Surgery- Type _________ Date ___________
Heart Stent(s) - Date _____________
Heart Transplant - Date: ___________
Heart Problems (Murmur, Valve Prolapse, other __________)
Artificial Heart Valve
Congenital Heart Defect
Pacemaker
Rheumatic fever or Rheumatic Heart Disease
High Blood Pressure/ Low Blood Pressure
Ulcers
Emphysema/COPD
Unexplained numbness in mouth; lump in mouth, throat or neck
Sores on lips, mouth or cheeks that do not heal in 2-3 weeks

Osteoporosis or Osteopenia
Osteoporosis Medication/Bisphosphonates
Diabetes (Insulin _______Units/day)
Diabetes (controlled by oral meds)
Fasting Blood sugars _______ Hgb 1 AC_______
Cancer type: ______________________
Chemotherapy - Date(s) _____________
Radiation – Date(s) _________________
Hepatitis
Liver Disease
Kidney Problems/ Kidney Transplant
Tuberculosis
Seizures/ Epilepsy
Thyroid Problems
HIV / AIDS
Stroke or TIA - Date: ___________
Drug Abuse and/or Alcohol Abuse
Psychiatric Problems – Type _______________
Problems with Anesthetic or Anesthesia

Allergies to medication ____

Any other conditions not mentioned above ____

Do you smoke? Yes / No **Smokeless tobacco?** Yes / No **Electric cigarettes?** Yes / No
Daily tobacco use? _____________ **How many years?** _____________
How long have you been with your present dentist? _________ **When was your last dental cleaning?** ________
Daily Oral Hygiene Routine: How often do you Brush your teeth? _______________ **Floss?** _______________

I certify that the above statements regarding my medical and dental conditions are complete and accurate. I will not hold Dr. Beddoe, or any member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature: ____ **Date:** ____________________________

PLEASE COMPLETE REVERSE SIDE OF PAPER, IF IT DOES NOT APPLY, WRITE NONE OR N/A. THANK YOU!

Dr. Signature:____ **Date:**______________________________

Prescription Medications	Dosage	How do you take it?	How often do you take this?	Why are you taking this?
Example: *Hydrochlorothiazide*	*50mg*	*Orally (by mouth)*	*Once Daily*	*High Blood Pressure*
Over-the-counter meds & nutritional supplements	**Dosage**	**How do you take it?**	**How often do you take it?**	**Why are you taking it?**
Example: *Calcium Supplement*	*1 tablet*	*Orally (by mouth)*	*Once Daily*	*Strengthen Bones*

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the use or disclosure of the protected health information ("PHI") as described below. By authorizing the use or disclosure of the PHI described below, I authorize the custodian of the PHI (1) to open the PHI for review or inspection by the person(s) identified below, and (2) to furnish the person(s) identified below with a copy of the PHI if he or she so requests.

Patient Name: ____ DOB: __________

Description of PHI requested: i.e. appointment reminder, inform of referral appointments, test results, prescriptions information, entire contents of dental record, including diagnosis, treatment details and financial information. I authorize the office of Dr. Ray Beddoe permission to contact me and leave messages pertaining to my dental care by a recording device or with the persons listed below.

I authorize the office of Ray A. Beddoe, D.M.D., Pharm.D., M.S. to release and/or disclose the PHI described above to:

Name: _______________________________________ Relation: ______________________

Name: _______________________________________ Relation: ______________________

Name: _______________________________________ Relation: ______________________

☐ Information is not to be released to anyone.

I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying the custodian of the PHI. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by this rule.

This Authorization will expire on the following date: ___________________________

****(If no expiration date is listed, this form will expire 3 years from date signed.)

____ ____________________
Signature Date