William B. Wynn, IV, D.D.S., M..S.
6565 S. Yale Avenue #1008
Tulsa, Oklahoma 74136
918-492-0737

Patient Information

Date:_________________________

Name:____Date of Birth:____________________

If a minor, Parent's name:____

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____ Minor_____

Patient's Social Security #:________--_______--________

Address:____

City:_______________________________ State:_____________________ Zip code:___________________

Home Phone:__________________________________ Cell Phone:_______________________________

Employer:____Phone:_______________________________

Spouse's Name:____

Spouse's Employer:__________________________________Phone:_______________________________

Spouse Date of Birth:___________________ Spouse Social Security #:________--_______--________

Whom may we thank for referring you?____

Person Responsible for Account:____

Name of Dental Insurance Company:____

Primary Dental Guarantor:____

Insurance ID#:____Phone #:_______________________

Medical Information

Are you currently under the care of a physician? Yes_____ No_____

If so, for what condition are you being treated?____

Physician's Name:____________________________________ Phone #:____

Physician's Address:____

Pharmacy Name:____Phone #:_______________________________________

Pharmacy Address / Intersection:____

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

Abnormal Bleeding	Alcohol Abuse
Allergies	Anemia
Angina Pectoris	Arthritis
Artificial Heart Valve	Artificial Joints or Replacements
Asthma	Biophosphate or Other Osteoporosis Medications
Blood Transfusion	Cancer / Chemotherapy / Radiation
Colitis	Congenital Heart Defect
Diabetes	Difficulty Breathing
Drug Abuse	Emphysema
Endocarditis	Epilepsy
Fainting Spells	Fever Blisters
Frequent Headaches	Glaucoma
HIV / AIDS	Heart Attack
Heart Surgery	Hemophilia
Hepatitis	High Blood Pressure
Kidney Problems	Liver Disease
Low Blood Pressure	Mitral Valve Prolapse
Organ Transplant	Pace Maker
Problems with Anesthetic or Anesthesia	Problems with Dental Work
	Psychiatric Problems
Rheumatic Fever	Seizures
Shingles	Sinus Problems
Sleep Apnea	Stroke
Thyroid Problems	Tuberculosis
Ulcers	Venereal Disease

Do You Smoke? _____Yes _____No If So, How Often?____

Have you ever had an unpleasant experience with nitrous oxide? _____Yes _____No

Other Conditions Not Mentioned Above:____

____

Please list hospitalization and surgery history:

____

____

____

List Any Current Medications:

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____

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____

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Allergies: (Please Circle All That Apply:)

Aspirin	Codeine or Other Narcotics	Anesthetic
Erythromycin	Latex	Metals
Penicillin	Tetracycline	Sulfa
Sedatives or Sleeping Pills	Other:____	

Women Only:

Are You Pregnant? _____Yes ______No If So, How Far Along?______________________

Are You Nursing? _____Yes _____No

Are You Taking Birth Control Pills? _____Yes _____No

Does Dental Work Make You Nervous or Apprehensive?_____Yes _____No

Please List The Reason You Are Here:

____

____

____

Who Is Your General Dentist:

____

When Were Your Teeth Last Cleaned?____

Have You Ever Had Periodontal Treatment:_____Yes _____No

Has Periodontal Disease Been Found In Your Mouth Before? _____Yes _____No

Please Circle Any Items You Use In Your Oral Care:

Toothbrush	Stimudents	Floss	Rubber Tip	Mouthwash
Water Pik	Toothpicks	Proxabrush	Electric Toothbrush	

Other:____

Notes:

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I hereby authorize payment of the insurance benefits otherwise payable to me, directly to William B. Wynn, IV D.D.S., MS., Oklahoma Periodontics, PC, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by my insurance carrier. I also authorize Dr. William B. Wynn to release any information acquired in the course of the examination to my insurance carrier. I authorize Dr. William B. Wynn to consult with my physician regarding medical conditions if necessary.

Patient Signature:____Date:________________________

Eastern Oklahoma Periodontics
William B. Wynn, IV, DDS, MS
6565 S. Yale, Suite #1008
Tulsa, Oklahoma 74136
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement. ______________________________

I have been offered and/or received a copy of Eastern Oklahoma Periodontics' Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or a third party. I understand that I may request a copy of the privacy policies at any time.

Print Patient's Name:______________________________

Patient/Parent/Guardian Signature:______________________________

Date:______________________________

Expiration: Three years from initial signature:______________________________

Expiration: Change in insurance coverage:______________________________

Expiration: Patient reaches the age of 18: (date of age 18)______________________________

I consent for the office of Eastern Oklahoma Periodontics to share my personal information with the following: (family, friends, co-workers, etc.)

Name: **Relationship:**

______________________________/______________________________

______________________________/______________________________

______________________________/______________________________

______________________________/______________________________

______________________________/______________________________

______________________________/______________________________

Eastern Oklahoma Periodontics
Center for Cosmetic Periodontics and Implant Dentistry
William B. Wynn, IV, D.D.S., M.S.
Kelly Professional Building – Suite 1008
6565 South Yale Avenue
Tulsa, OK 74136

Patient E-Mail Consent Form

Patient name: ______________________
Patient address: ______________________
E-mail: ______________________

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. William B. Wynn and Eastern Oklahoma Periodontics ("Practice") are not encrypted, so E-mails may not be secure. Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail senders can easily misaddress an E-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
Practice server could go down and E-mail would not be received until the server is back on-line.
i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Practice cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Dr. Wynn are not liable for improper disclosure of confidential information that is not caused by our intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. Our office cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.
b) If the patient's E-mail requires or invites a response from Practice, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.
c) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
d) All E-mail will usually be printed and filed in the patient's medical record.
e) Office staff may receive and read your messages.
f) Practice will not forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.

j) In the event that the patient does not comply with *the conditions* herein, Practice may terminate patient's privilege to communicate by E-mail with Practice.

3. <u>INSTRUCTIONS</u>

To communicate by E-mail, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (<u>e.g.</u>, medical question, billing question) in the subject line.
d) Inform Practice of changes in his/her E-mail address.
e) Acknowledge any E-mail received from the Practice and/or Physician.
f) Take precautions to preserve the confidentiality of E-mail.
g) Protect his/her password or other means of access to E-mail.

4. <u>PATIENT ACKNOWLEDGMENT AND AGREEMENT</u>

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Dr. Wynn and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge Dr. William B. Wynn and Oklahoma Periodontics, P.C., doing business under the tradename "Eastern Oklahoma Periodontics," and its' affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature ______________________

Date ______________________________

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Patient Consent for Medical Photography

I, ________________________, give permission to Dr. William B. Wynn, IV, or designated staff members of Eastern Oklahoma Periodontics, to take all necessary radiographs, study models, photographs, or any other required diagnostic aids as part my dental records. I understand that the images may be used in medical publications or for Eastern Oklahoma Periodontic's marketing and advertising purposes, without disclosing my name or other identifying information, as I have designated below. By consenting to the use of medical photographs in this manner, I understand that I will not receive payment from any party. Refusal to consent to use of these images for purposes other than my medical records will in no way affect the medical care I receive from Eastern Oklahoma Periodontics. I understand that I may notify Eastern Oklahoma Periodontics, in person or in writing, if I wish to withdraw my consent to my medical photographs being used for further publications.

By signing below, I confirm that this consent form has been explained to me in terms which I understand.

1. I consent to my images being used in medical publications, including medical journals, textbooks, and electronic publications, case presentations, and for purposes of advertising and marketing the services of Eastern Oklahoma Periodontics. Although any photographs will be used without disclosing my name or other identifying information, I understand that the images may be seen by members of the general public, in addition to medical professions and researchers who regularly use these publications in their professional education.

Signature: ____________________________ Date: ____________________________

2. I agree to the use of my images for medical records ONLY.

Signature: ____________________________ Date: ____________________________