Christian H Pilgrim DDS

NAME _____ DOB _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME# _____ CELL# _____ SSN: _____

EMAIL _____

CIRCLE APPROPRIATE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENTS EMPLOYER _____ WORK# _____

BUSINESS ADDRESS _____ CITY _____ ST _____ ZIP _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PHARMACY _____ LOCATION _____

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____

_____

Responsible Party(if different)

NAME _____ RELATIONSHIP TO PAITENT _____

ADDRESS _____ CITY _____ ST _____ ZIP _____ PHONE# _____

SSN# _____ DOB _____ SEX _____

EMPLOYER _____ WORK# _____

Insurance Information

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

DOB _____ SSN# _____ SEX _____

EMPLOYER _____ WORK # _____ GROUP# _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child or me during the period of such dental care to third party payers/health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment for all services rendered on my behalf or my dependents. I understand there will be no patient refunds issued if there are 2 or more missed appointments.

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment and healthcare operations.

Sign_____Date_____

Christian H Pilgrim, DDS, PC, INC

Date 3/21/2019

New Medical History 2019

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, c

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
Are you taking any medications, pills, or drugs?	◯ 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	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Hepatitis A,B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Herpes/ Cold sores	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High/Low 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	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ 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
Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ 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
Ulcers	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Yellow Jaundice	◯ 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:_____

Christian H Pilgrim, DDS

717 SW 119th St

Oklahoma City, Oklahoma 73170

405-691-0836 email: cpilgrimdds@sbcgloal.net

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below**. You may opt out by checking the "Do not Release Information" line here _____

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of Christian H Pilgrim, DDS, on my behalf regarding **(please check all items authorized).**

Name of authorized person(s):_____

Relationship_____ Phone #_____

___Appointments ___Financial ___Dental Treatment ___Insurance
___Other (explain)

Name of authorized person(s):_____

Relationship_____ Phone #_____

___Appointments ___Financial ___Dental Treatment ___Insurance
___Other (explain)

Name of authorized person(s):_____

Relationship_____ Phone #_____

___Appointments ___Financial ___Dental Treatment ___Insurance
___Other (explain)

Image release form

I hereby grant Christian H Pilgrim, DDS permission to use my likeness in photographs, video recordings or electronic images in any and all of its publications, including website entries, without payment or any other consideration. I understand and agree that these materials will become the property of the organization and will not be returned. I hereby irrevocably authorize the organization to edit, alter, copy, exhibit, publish or distribute these images for purposes of publicizing the organization's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image. I hereby hold harmless and release and forever discharge the organization from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name, or if I am under age 18, a parent or guardian has signed below. I have read this release before signing below and I fully understand the contents, meaning and impact of this release.

_____ _____

(Signature) (Date)

_____

(Printed Name)

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing release on behalf of this person.

_____ _____

(Parent/Guardian's Signature) (Date)

_____

(Parent/Guardian's Printed Name)