Oasis Dentistry

1621 South Eucalyptus Avenue ▪ Broken Arrow, OK 74012
Berkshire Medical Plaza, Suite 101
918 / 250-0624

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. If you have any questions, or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ *Birthdate* _____ *Soc Sec. #* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Cell Phone* _____ *Work Phone* _____

E-mail Address _____ *How would you prefer we contact you?* _____

Marital Status ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* *Sex:* ☐ *Male* ☐ *Female*

Patient's Employer (Name of School if Student) _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ *Phone* _____

How would you prefer we contact you to confirm appointments? ☐ *Cell Phone* ☐ *Home Phone* ☐ *Work Phone* ☐ *E-Mail*

Responsible Party

Check box if same as above. ☐

Name of Person Responsible for Payment _____ *Relationship to Patient* _____

Birthdate _____ *Social Security #* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Cell Phone* _____ *Work Phone* _____

Email Address _____

Is this person currently a Patient in our Office? ☐*Yes* ☐*No*

We will file with your insurance company as a courtesy to you; however, we cannot guarantee coverage for services.
We require payment in full of any portion not to be covered by insurance on the date of services.
Please make arrangements, prior to you appointment date, if you need assistance with financial arrangements.

Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *Social Security Number* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Cell Phone* _____ *Work Phone* _____

Name of Employer _____

Insurance Company _____ *Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Policy # _____ *Group#* _____

Secondary Insurance Information *(if applicable)*

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *Social Security Number* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Cell Phone* _____ *Work Phone* _____

Name of Employer _____

Insurance Company _____ *Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Policy# _____ *Group#* _____

— *Over Please* —

Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

		Yes	No
1.	Are you under medical treatment now?	☐	☐
2.	Have you been hospitalized for any surgical operation(s) or serious illness? If Yes, please explain _____	☐	☐
3.	Are you taking any Prescription Medication? If yes, please list: _____	☐	☐
4.	Are you taking Non-Prescription Medicine or Vitamins? If yes, Please list: _____	☐	☐
5.	Have you ever been told you need any pre-medication prior to dental treatment?	☐	☐
6.	Do you use tobacco? Current/Previous	☐	☐
7.	Current or previous drug use ? (Including Prescription Marijuana) If Yes, Please list _____	☐	☐

8. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Pain Medications	☐	☐
Nitrous	☐	☐
Iodine	☐	☐
Latex Rubber	☐	☐
Metal (e.g. nickel, mercury etc.)	☐	☐
Sedatives	☐	☐
Sulfa Drugs	☐	☐
Other (please list) _____		

	Yes	No
AIDS or HIV Infection	☐	☐
Alzheimer's Disease/Dementia	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Asthma	☐	☐
Autism/Aspergers	☐	☐
Autoimmune Disease	☐	☐
Back or neck pain	☐	☐
Behavioral or Learning Disability	☐	☐
Bleeding/Clotting Disorder	☐	☐
Blood-cell Disorder	☐	☐
Cancer	☐	☐
Chest Pains/Angina	☐	☐
Chemo/Radiation Therapy	☐	☐
Depression/Anxiety	☐	☐
Diabetes Type 1 or 2	☐	☐
Epilepsy/Seizures/Fainting	☐	☐
Eating Disorder (current/previous)	☐	☐
Frequent Headaches	☐	☐
Frequent Heartburn/Acid Reflux	☐	☐
Glaucoma/other eye issues	☐	☐
Heart Attack	☐	☐
Heart Disease/Trouble	☐	☐
Heart Pacemaker/Defibrillator	☐	☐
Hepatitis	☐	☐
High/Low Blood Pressure	☐	☐
HPV	☐	☐
Irregular Heart Beat	☐	☐
Joint Replacement or Implant	☐	☐
Kidney Disease	☐	☐
Leukemia	☐	☐
Liver Disease/Jaundice	☐	☐
Mitral Valve Prolapse/Heart Murmur	☐	☐
Oral Herpes/Fever Blisters	☐	☐
Organ or Bone Marrow Transplant	☐	☐
Osteoporosis/Osteopenia	☐	☐
Psychiatric Care	☐	☐
Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐
Seasonal Allergies	☐	☐
Sexually Transmitted Disease	☐	☐
Sleep Apnea	☐	☐
Stroke	☐	☐
Substance Abuse (current/previous)	☐	☐
Thyroid Problems/Disease	☐	☐
Tuberculosis	☐	☐
Ulcers/Gastrointestinal Disease	☐	☐
Ever taken Phen-Fen/Redux	☐	☐
Have you ever taken Bisphosphonates?	☐	☐
Other _____	☐	☐

Women Only:

Are you pregnant or think you may be pregnant? Yes__ No__ Are you nursing? Yes__ No__ Are you taking oral contraceptives? Yes__ No__

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

		Yes	No
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.	Are you teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Do you feel pain to any of your teeth?	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Have you had any head, neck or jaw injuries?	☐	☐
7.	Have you experienced any of the following problems in your jaw?		
	Clicking	☐	☐
	Pain (joint, ear, side of face)	☐	☐
	Difficulty in opening & closing	☐	☐
	Difficulty in chewing	☐	☐
8.	Do you clench or grind your teeth?	☐	☐
9.	Do you bite your lips or cheeks frequently?	☐	☐
10.	Have you had any difficult extractions in the past?	☐	☐
11.	Have you had any prolonged bleeding following extractions?	☐	☐
12.	Have you had any orthodontic treatment?	☐	☐
13.	Do you wear dentures or partials? Date of placement _____	☐	☐
14.	Do you experience a dry mouth?	☐	☐
15.	Do you like your smile?	☐	☐

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 records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize & request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

We reserve the right to charge for appointments cancelled or broken without 48 hours advance notice!

Signature of Patient (Parent/Guardian) _____ Date _____

DDS _____

CARIES RISK ASSESMENT

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1. **How often do you drink liquids between meals (other than water)?**
   a. Never or rarely_____ Occasionally_____ Frequently_____

2. **Do you ever experience heartburn or acid reflux?**
   a. Never or rarely_____ Occasionally_____ Frequently_____

3. **Do you notice having a dry mouth?**
   a. Never or rarely_____ Occasionally_____ Always_____

4. **How often do you take medication (besides antibiotic for an infection)?**
   a. Never or rarely_____ Frequently_____ Daily_____

5. **Do you have a history of receiving radiation therapy to your head and/or neck? Or have you been diagnosed with Sjogren's syndrome?**
   a. No_____ Unsure_____ Yes_____

6. **Do you currently have braces, a partial, or any other type of oral appliance?**
   a. No_____ Yes_____

7. **How many of your teeth have had a cavity in the last 3 years that you're aware of?**
   a. None_____ 1-3_____ 4 or more_____

8. **Have you ever noticed or been told you have gum recession? (The gums have moved down and the root surface is visible.)**
   a. No_____ Unsure_____ Yes_____

9. **How often do you notice plaque on your teeth?**
   a. Never or rarely_____ Sometimes_____ Frequently_____

10. **How often do you floss?**
    a. Daily_____ Weekly_____ Rarely or Never_____

11. **Do you use any type of tobacco or vape?**
    a. No_____ Occasionally_____ Yes_____

12. **Have you ever noticed discoloration on your teeth?**
    No_____ Unsure_____ Yes_____

0 points for every answer in the **FIRST** column
1 point for every answer in the **MIDDLE** column _____
2 points for every answer in the LAST column _____
TOTAL POINTS _____

- **0-3** Very low risk of cavities
- **4-7** Low risk of cavities
- **8-11** Moderate risk of cavities
- **12+** High risk of cavities

Name: _____ Date: _____

OASIS DENTISTRY
MYRNA DOMONEY, DDS, PLLC
KALI DOMONEY MILNER, DDS
1621 South Eucalyptus Avenue
Berkshire Medical Plaza, Suite 101
Broken Arrow, Oklahoma 74012
918-250-0624

Name: _____ Date: _____
Date of birth: _____

I consent for the office of Oasis Dentistry *(Dr. Myrna Domoney, DDS, PLLC)* may share my personal information with any or all of the following: laboratories used for dental work, insurance carriers, other dentists/specialists, collection agencies, primary care physicians, dental photos or patient smile photos for display.

Name / Relationship
(Anyone we can speak with regarding your appointment or account):

1. _____ / _____
2. _____ / _____
3. _____ / _____

I agree that the dental practice may communicate with me at the phone numbers and/or email addresses provided by me**. I am aware that there is some level of risk that third parties may be able to read unencrypted emails, or listen to voice messages.** I am responsible for providing the dental practice any updates to my phone numbers or email address. I can withdraw my consent to electronic communication by email or written notice.

Patient Signature: _____

Note: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may **Decline** to treat you or continue treating you if you **revoke** this Consent.

OASIS DENTISTRY
Myrna Domoney DDS PLLC
Kali Domoney Milner DDS

1621 South Eucalyptus Avenue
Berkshire Medical Plaza, Suite 101
Broken Arrow, Oklahoma 74012
918-250-0624

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Oasis Dentistry's 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 third party. I understand that I may request a copy of the privacy policies at any time.

Expiration -- 3 Years from Initial Signature; Insurance Change; Patient reaches age of 18

I consent for the office of Drs Myrna Domoney and Kali Domoney Milner to share my personal information with the following: (family, friends, etc.)

Signature: _____

Patient Parent Guardian / Other

Financial Responsibility Agreement
Oasis Dentistry
Myrna Domoney, DDS and Kali Domoney Milner, DDS

I accept full financial responsibility for dental expenses incurred at Oasis Dentistry:
I understand that my insurance plan is a contract between myself and the insurance provider. Oasis Dentistry does not have control over the benefits and therefore is not responsible for what insurance does **not** cover. I understand that my insurance will be filed by this office and that what is not covered will be forwarded to me in the form of a statement of services and that I am responsible for paying the balance.
I understand that I am responsible for:

- Providing up to date insurance information at the time of my appointment and that if I do not provide this information I will be responsible for all fees if the insurance denies payment due to untimely filing.
- All services provided that are not covered by my insurance plan.
- My co-payment portion at the time of service.
- Any cosmetic procedures performed that is not a covered service under my insurance plan.
- All collection cost and attorney fees involving the collection of my account if I default on any part of this agreement.
- Any returned checks and subsequent fees.

To the best of my knowledge, I have provided the most current insurance information available for the filing and collection of benefits owed to Oasis Dentistry. I understand that it is my responsibility to provide or know my insurance benefit information at the time services are rendered and accept full responsibility if I do not.

I understand that I am responsible for the scheduling of my appointments. I understand that the staff of Oasis Dentistry **may** make efforts to remind me of my appointments, but it is my responsibility to remember my appointments and to make appropriate arrangements to be at my appointments on time. If I cannot come to my appointment, it is my responsibility to contact Oasis Dentistry with at least 48 hours notice.

I understand that if I fail to meet any of these policies, I may be charged up to the full amount of scheduled treatment for my missed appointment or if I am late to my appointment and need to reschedule.

Oasis Dentistry accepts payment in the form of cash, check, Visa, Mastercard, Discover, and Care Credit®

If you need to make alternate payment arrangements, please discuss this with us BEFORE your appointment.
I have read and understand the Financial Agreement.

_____ _____
Signature Date

_____
Print Name

Consent for Use of Electronic Communication

Name: _____

Date of Birth: _____

I give my permission for Oasis Dentistry to use the following methods of communication for the purposes of supplying information regarding my appointments, my account, or my dental treatment, including leaving messages, for myself or my dependents.

Yes____ No ____ Home phone: _____

Yes____ No ____ Cell phone: _____

Yes____ No ____ Work phone: _____

Yes____ No ____ Email: _____

Yes____ No____ Spouse/Parent/Other: _____

_____ _____

Signature Date

We screen all of our new patients for sleep apnea. Please complete this brief form to determine if further discussion is needed. If you would like more information on sleep apnea, please let us know. Thank you!

Name _____ Date _____

Berlin Questionnaire©

Category 1

1. Do you snore?
    a. Yes
    b. No
    c. Don't know

If you answered 'yes':

2. Your snoring is:
    a. Slightly louder than breathing
    b. As loud as talking
    c. Louder than talking

3. How often do you snore?
    a. Almost every day
    b. 3-4 times per week
    c. 1-2 times per week
    d. 1-2 times per month
    e. Rarely or never

4. Has your snoring ever bothered other people?
    a. Yes
    b. No
    c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
    a. Almost every day
    b. 3-4 times per week
    c. 1-2 times per week
    d. 1-2 times per month
    e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?
    a. Almost every day
    b. 3-4 times per week
    c. 1-2 times per week
    d. 1-2 times per month
    e. Rarely or never
    f.
7. During your waking time, do you feel tired, fatigued, or not up to par?
    a. Almost every day
    b. 3-4 times per week
    c. 1-2 times per week
    d. 1-2 times per month
    e. Rarely or never
8. Have you ever nodded off or fallen asleep while driving a vehicle?
    a. Yes
    b. No

If you answered 'yes':

9. How often does this occur?
    a. Almost every day
    b. 3-4 times per week
    c. 1-2 times per week
    d. 1-2 times per month
    e. Rarely or never

Category 3

10. Do you have high blood pressure:
    a. Yes
    b. No
    c. Don't know