Massad Center for Higher Learning
302 South Lewis Ave.
Tulsa, OK 74104

REGISTRATION AND MEDICAL HISTORY

Patient Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Day Phone #: _____ Evening Phone #: _____

Email Address: _____

Patient Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name: _____ Date of Birth: _____ Age: _____

Patient Employed by: _____

Address of Employer: _____

Spouse Employed By: Spouse Work #: _____

Whom may we thank for referring you? _____

In Case of emergency, whom should we contact? _____ Phone: _____

Person Responsible for Payment of Account: _____

_____
(address if different than above)

In the follow questions, circle yes, no or check box, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes☐No☐
2. Has there been any change in your general health within the past year? ..... Yes☐No☐

   If yes, please describe: _____
3. My last physical examination was on: _____

4. Are you now under the care of a physician? ..... Yes☐No☐
If yes, please describe: _____

5. The name, address & phone number of my physician is: _____

_____

6. Have you had any serious illness or operation? ..... Yes☐No☐

If yes, please describe: _____

7. Have you been hospitalized or had a serious illness within the past five (5) years? ..... Yes☐No☐

If yes, please describe: _____

8. Do you have or have you had any of the following diseases or problems? ☐YES ☐NO (If yes please check all that apply)

☐Damaged heart valve	☐Artificial heart valves	☐Heart murmur
☐Rheumatic fever	☐Congenital heart lesions	☐Cardiovascular disease
☐Heart trouble	☐Heart attack	☐Coronary insufficiency
☐Coronary occlusion	☐High blood pressure	☐Arteriosclerosis
☐Stroke	☐Congestive hear failure	☐Pace maker
☐None of the Above		

Please describe all that are checked: _____

_____

9. Do you have: ☐YES ☐NO (Please check all that apply)

☐Allergies	☐Sinus trouble	☐Asthma or hay fever
☐Hives or skin rash	☐Fainting spells or seizures	☐Diabetes
☐Hepatitis	☐Jaundice	☐Liver disease
☐Arthritis	☐Low blood pressure	☐Stomach ulcers
☐Kidney trouble	☐Tuberculosis	☐Venereal disease
☐Epilepsy	☐Psychiatric problems	☐Cancer

☐Do you have a persistent cough or cough up blood?

☐Inflammatory rheumatism (painful swollen joints)

☐AIDS or other immunosuppressive disorders

☐Other_____

☐None of the Above

Please describe all that are checked:_____

_____

10. Do you bleed easily or have any blood disorders such as anemia? ..... Yes☐No☐

If yes, please describe: _____

11. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck? ..... Yes☐No☐

If yes, please describe: _____

12. Do you use tobacco products? .....Yes☐No☐

If yes, please describe: _____

13. Are you taking any drug or medicine? ..... Yes☐No☐

If yes, please describe: _____

_____

14. How many medications do you take on a regular basis?

15. Are you taking any of the following?☐ YES ☐NO (please check all that apply)

☐Antibiotics or sulfa drugs

☐ Anticoagulants (blood thinners) ☐ Cortisone (steroids) ☐ Nitroglycerin

☐ Tranquilizers ☐ Antihistamines ☐Aspirin

☐ Digitalis or drugs for heart trouble

☐ Insulin, tolbutamide (Orinase) or similar drug

☐ Oral contraceptive or other hormonal therapy

☐ Medicine for high blood pressure

☐ Other (please list) _____

☐None of the Above

Please describe all that are checked: _____

_____

16. Are you allergic or reacted adversely to: ❑ YES ❑ NO (please check all that apply)

❑ Local anesthetics

❑ Sulfa drugs

❑ Aspirin

❑ Codeine or other narcotics

❑ Peanuts

❑ Raisins

❑ Penicillin or other antibiotics

❑ Barbiturates, sedatives, or sleeping pills

❑ Iodine

❑ Latex

❑Popcorn or corn products

❑ Apples

❑ Other _____

❑ None of the Above

❑ None of the Above

If checked please describe: _____

17. Have you had any serious trouble associated with any previous dental treatment? .... Yes No

If yes, please describe: _____

18. Do you have any disease, condition, or problem not listed above that we should know about? ..... Yes No

If yes, please describe: _____

19. Are you wearing contact lenses? ..... Yes No

20. Have you had anything to eat or drink in the last 4 hours? ..... Yes No

21. Are you wearing removable dental appliances? ..... Yes No

22. Are you pregnant? ..... Yes No

23. Do you have any problems associated with your menstrual period? ..... Yes No

24. Are you nursing? ..... Yes No

I hereby authorize Joseph J. Massad, DDS and Associates to obtain verbal and/or written medical information from my physician or family physician to aid in a more complete medical history if needed.

If we need to refer you to another dentist, specialist, or need to contact a family member we will need the following authorization signed for the release of your records.

I authorize Joseph J. Massad, DDS and Associates to release any and all information, which they possess relative to my exam or examination findings, x-rays, and treatment to the referring dentist, specialist, insurance carrier, or family member. I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ ____/____/____

Signature of Patient/Guardian Day Month Year

_____ ____/____/____

Signature of Witness Day Month Year

_____ ____/____/____

Signature of Dentist Day Month Year

PDl

JOSEPH J. MASSAD, DDS & Associates
302 South Lewis Ave.
Tulsa, OK 74104

DENTAL PATIENT HISTORY

Patient Name: _____ Age: _____ Sex: ❑ Male ❑ Female

It is often helpful to have some background information relevant to your experience with dentures. Please assist us by answering the following questions.

What is your chief denture complaint: (check all that applies)

❑ Looseness ❑ Cannot chew ❑ Soreness ❑ Appearance

Please Explain:

_____

_____

_____

1. Do you have any remaining natural teeth? ..... Yes No
2. I have presented myself for:

   ☐An evaluation to be fitted for my first denture.

   ☐At present I have teeth, but I would like to have them removed.

   ☐All teeth have been removed prior to this visit. Date of removal:

   _____

   ☐An evaluation for replacement of my existing denture.

   ❑ An evaluation for refitting my existing denture.

   ❑ A repair of my existing denture.

   ❑ A replacement of my existing denture.
3. My present denture was made approximately _____ years ago.
4. Are you pleased with:

   The fit of your existing denture? ..... Yes No

   The function of your existing denture? ..... Yes No

PDI

The appearance of your denture?..... Yes No

The color or shade of your teeth?..... Yes No

The color or shade of your gums? ..... Yes No

_____

Initial

5. Do you have any known allergies to the following? (please check all that apply) ❑ YES ❑ NO

   ❑ Latex?

   ❑ Methyl Methacrylate (Denture Acrylic)?

   ❑ Ethyl Methacrylate (Denture Acrylic)?

   ❑ Raisins?

   ❑ Peanuts?

   ❑ Popcorn or any corn products?

   ❑ Apples?

6. What is your attitude about having dentures? ❑ Good ❑ Average ❑ Poor ❑ Not sure yet

7. How do you rate your expectations for your new dentures?

   ❑ High ❑ Medium ❑ Low ❑ Not sure yet

8. How much water do you drink on a daily basis?

_____

10. When was your existing *Upper* denture placed?

_____

11. How long have you been wearing *Upper* dentures?

_____

12. When was the last time an *Upper* denture was made?

_____

13. How many *Upper* dentures have you had in all?

_____

14. When was your existing *Lower* complete or partial denture placed?

_____

15. How long have you been wearing *Lower* complete or partial dentures?

_____

PDI

16. When was the last time a *Lower* complete or partial denture was made?

_____

17. How many *Lower* complete or partial dentures have you had in all?

_____

Please chose the one that best describes you:

- ❑ I want my new denture to be perfect.
- ❑ I will accept other than perfect dentures.
- ❑ I just want to eat, looks do not matter.
- ❑ Looks are the most important thing to me.
- ❑ Chewing is the most important thing to me

_____

Initial

Please use the space below to provide us with any additional information that may assist us in better serving you. Please tell us what you expect.

_____

_____

_____

_____

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and answered all of the above questions to the best of my knowledge.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient of Personal Representative

_____

Description of Personal Representative's Authority

____/____/____

Day Month Year

Patient Name _____ Date _____

PHI Medications

Joseph J. Massad, DDS & Associates

302 South Lewis Ave., Tulsa, Oklahoma 74104

(918) 749-5600

Please list below any and all medication you are currently taking.

	Medication	Dosage	Taken	Reason
Ex:	Asprin	81mg	2 tabs in the A.M.	Heart health
1.				
2.				
3.				
4.				
5.				

Model Release Form

Authorization to Reproduce Physical Likeness

For good and valuable consideration, the receipt of which from (PrintName) _____ is acknowledged, I here by expressly grant to said Joseph J. Massad D.D.S. & Associates and to its employees, agents and assigns, the right to photograph me and use my picture, silhouette and other reproductions of my physical likeness (as the same may appear in any still camera photograph and/or motion picture film), in and in connection with the exhibition, theatrically, on television or otherwise, of any motion picture or motion pictures in which the same may be used or incorporated and also in the advertising, exploiting and/or publicizing of any such motion picture, but not limited to television or theatrical motion pictures.

I hereby certify that I have read the foregoing and fully understand the meaning and effect thereof, and intending to be legally bound, I have hereunto set my hand this _____ day of _____, 20____.

Signature _____ Date_____

Witness _____ Date_____

PATIENT CONSENT FORM

I, _____ [NAME OF PATIENT / PARENT / GUARDIAN / RELATIVE***] (the "Licensor"), give my permission to Massad Enterprises Inc. and Dr. Joseph J. Massad ("Massad") to use clinical information/video/photographic material relating to _____ [MYSELF OR SPECIFY RELATIONSHIP***] in any and all educational or commercial publications in all media and languages throughout the world.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information; including any images which may be taken during my treatment.

This release is strictly designed to give permission to Massad, his heirs, legal representatives and assigns, to take photographs, slides, x-rays and/or videos ("Images") of my face, jaws, mouth, and teeth, and to use those Images as a record of my care and for educational and commercial purposes in study club meetings, lectures, seminars, demonstrations, advertisements and professional publications (including but not limited to journals, magazines, text books).

I understand that:

The Images will be used only in educational and commercial publications intended for health professionals

(1) My name will not be published and Massad will endeavor to ensure that I cannot be identified from the clinical information, other than in relation to identifiable material (such as videos/ photographic material) for which I give consent. However I also understand that there is a low possibility that I may be identified from the clinical information.

(2) If the publication or product is published on an open access basis, I understand that it may be accessed freely throughout the world.

I understand that by allowing Massad, his heirs, legal representatives and assigns to use my Images, he is able to share "before and after" images to educate and explain procedures and possible results of treatment. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these Images.

I waive any right to compensation for use of my Images, now or in the future.

** In cases where the patient has died or is incapable of giving consent, consent may be given by the next of kin. If the patient is under the age of 16, consent should be given by a parent or guardian.

I am over 18 years of age and I have read and understand the above terms and stipulations and agree to adhere to them.

Name: _____ Mobile: _____

Address: _____

Signature: _____ D.O.B: _____

Today's Date: _____ Email: _____

Patient Consent Form

To record a patient's consent to publication of information relating to them or a relative, in a Wiley publication.

Name of patient:_____

Title of publication/product:_____

Principal author/editor:_____

Principal author/editor's address:_____

_____

I, [.....NAME OF PATIENT / PARENT / GUARDIAN / RELATIVE***] (the "Licensor"), give my permission to use clinical information/video/photographic material relating to [.....NAME AND RELATIONSHIP***] in the publication identified above to be published by John Wiley & Sons, Inc. or one of its affiliated companies ("Wiley"), such permission to extend to publication of the information by Wiley and its licensees in all media and languages throughout the world.

***In cases where the patient has died or is incapable of giving consent, consent may be given by the next of kin. If the patient is under the age of 16, consent should be given by a parent or guardian.

I understand that:

The information/video/photographic material will be used only in educational publications intended for health professionals

(1) My name will not be published and Wiley will endeavour to ensure that I cannot be identified from the clinical information, other than in relation to identifiable material (such as videos/photographic material) for which I give consent. However I also understand that there is a low possibility that I may be identified from the clinical information.

(2) If the publication or product is published on an open access basis, I understand that it may be accessed freely throughout the world.

This Agreement shall be governed by, and construed in accordance with: 1) the laws of England and Wales, if the Licensor is located outside of the United States, or 2) the laws of the State of New York, if the Licensor is located in the United States. In relation to any legal action or proceedings to enforce this Agreement or arising out of or in connection with this Agreement each of the parties irrevocably submits to the non-exclusive jurisdiction of the courts: 1) in England and Wales, if the Licensor is located outside of the United States, or 2) in New York, New York, if the Licensor is located in the United States.

***SIGNATURE OF PATIENT/PARENT// GUARDIAN / NEXT OF KIN .....

[ADDRESS] _____

_____

_____

[DATE]_____

SIGNATURE OF HEALTH PROFESSIONAL OBTAINING PERMISSION (IF APPROPRIATE)

.....

[ADDRESS] _____

_____

_____

[DATE]_____

Note to principal author: The original signed consent form should be retained by the principal author.

Note to health professional: In addition to the consent form, please ensure that any other necessary permissions are cleared for use of the information, including any permissions required for use of information contained in medical records.

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Title of publication/product:_____

Principal author/editor:_____

Principal author/editor's address:_____

_____

I, [.....NAME OF PATIENT / PARENT / GUARDIAN / RELATIVE***] (the "Licensor"), give my permission to use clinical information/video/photographic material relating to [.....NAME AND RELATIONSHIP***] in the publication identified above to be published by John Wiley & Sons, Inc. or one of its affiliated companies ("Wiley"), such permission to extend to publication of the information by Wiley and its licensees in all media and languages throughout the world.

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***SIGNATURE OF PATIENT/PARENT// GUARDIAN / NEXT OF KIN .....

Joseph J. Massad, D.DS. & Associates
302 South Lewis Ave.
Tulsa, Oklahoma 74104
(918) 749-5600

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by I to anyone outside of our practice. You may gain access to this information if you desire.

Please review it carefully. The privacy of your health information is important to us.

- **Our Legal Duty**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning you health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect on April 14, 2003 and will remain in effect.
We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are
permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice
and make the new notice available upon request.
You may request a copy or our notice at any time. For more information about our privacy practices, or for additional
copies of this notice, please contact us using the information listed at the end of this notice.

- **Uses and Disclosures of Health Information**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducing training programs, accreditation, certification, licensing or credentialing activities.

Public Health Activities: We may disclose medical information about you for public health activities and purposes. These purposes generally include the following:

~ Preventing or controlling disease, injury or disability;
~ Reporting vital events such as births and deaths;
~ Reporting child abuse or neglect;
~ Reporting adverse events or surveillance related to food, medications or defects or problems with products;
~ Notifying persons of recalls, repairs or replacements of products they may be using; or
~ Notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder of your appointment for treatment or medical care.

Research: As an academic learning center, we may use and disclose medic a l information about you for research purposes . We may con tact you about research projects that you may qualify for. We will only use and disclose your information for a research project if we obtain permission or if the need to obtain your permission has been waived by the Massad Center for Higher Learning Review Board, which is a designated review committee that meets Federal requirements.

To Avert a Serious Threat to Health or Safety: We may use or disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety to the public or another person. Disclosure would only be to the persons who could help prevent or reduce the threat.

- **Your Authorization**

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e .g. a family member picking up records, referral to a dental specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give a written authorization , we cannot use or disclose your health information for any reason except those described in this notice.

- **To Your Family and Friends**

We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, by only if you agree that we may do so .

- **Persons Involved in Care**

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location , your general condition, or death. 1f you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your health care . We will also use our profess tonal judgement and our experience with common practice to make reasonable inferences of

your best interest in allowing a person to pick up filled prescriptions , medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Relation Services: Dr. Massad does conduct lectures utili zing photos, x-rays, etc. We will not , however, use your health information for marketing communications without your written authorization .

Required by Law: We may use or disclose your health information when it is required by law to do so (i .e. missing person, etc.)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to lawfully authorize federal officials health information required by lawful intelligence, counterintelligence, and other national security activities . We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards , or letters) .

Patient Rights

Right to Access and Copy: You have the right to access and obtain a copy of the medical information that we maintain about you. This right docs not apply to certain information, such as psychotherapy notes , information compiled for use in or created in anticipation of a civil , criminal or administrative action or proceed ing, or certain laboratory test results subject to the Clinical Laboratories Improvement Act of 1988.

To access your medical information while you arc under the treatment of the Massad Center for Higher Leaning, please contact the administrative office directly or in writing at 302 South Lewis Ave., Tulsa, OK 74104, (918) 749-5600 . You may request that we provide copies in a format other than photocopies. We will use the format you request unless we can not practicably do so. We may charge you a reasonable cost-based fee for expenses such as copies and staff lime.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associated disclosed your health information for any purpose. other than treatment, payment. healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do , we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing.

Your request must specify the alternative means or locations, and provide satisfactory explanation how payment s will be hand led under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing. It must explain why the information should be amended . We may deny your request under certain circumstances.

Changes To This Notice

We may revise this Notice to reflect any changes in our privacy practices . We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

Questions and Complaints:

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that l) We may have violated your privacy right, 2) You disagree with a decision we made about access to your health information, 3) In response to a request you made to amend or restrict the use or disclosure of your health information or 4) To have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right lo the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services .

Contact Officer:	Joseph J. Massad , D .D.S.
Telephone:	918-749-5600
Address:	302 South Lewis Ave., Tulsa, OK 74104

Joseph J. Massad, DDS & Associates
302 South Lewis Ave.
Tulsa, Oklahoma 74104
918-749-5600

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have received a copy of Dr. Massad's Notice of Privacy Practices.

_____
Please Print Patient Name

_____
Patient / Guardian Signature

_____ / _____ / _____
Day Month Year

Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual Refused to Sign
__ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other