ALL ABOUT Smiles DENTISTRY

Dr. Jason Carper, D.D.S ~ Dr. Chasity Carper, D.D.S.

Welcome to Our Practice!

We are pleased that you have chosen us as your dental care providers! We feel quite confident that you will find our staff friendly and extremely knowledgeable in caring for your dental concerns.

Mission Statement: Our mission at All About Smiles Dentistry is to serve the community with superior dental care for the entire family. We strive to create a sense of calm, comfort, and kindness for our patients. We value honesty and only recommend treatment for our patients that we would have for ourselves. Patients will be at ease knowing that our entire staff attends continuing education courses regularly to stay current with the latest advances in dentistry. At All About Smiles we aim to keep our appointment times because we value your time as we expect you to respect ours.

Enclosed please find a patient health history, our appointment policy, and a copy of our financial options. Will you please take a moment to fill out the enclosed paper work, sign where appropriate and bring with you the day of your appointment?

We look forward to meeting you soon! Please call if you have any questions.

Dr. Jason, Dr. Chasity, and staff

ALL ABOUT Smiles DENTISTRY

Appointment Policy

We are pleased you have chosen to become patients at our office. We take pride in our office and our practice, and will strive to make dental visits a pleasant, even enjoyable, experience for you and your family.

Because we know your time is valuable, as is our time, it is necessary for you to arrive at your appointment on time. We do not put more than one patient in each appointment block. Your time schedule is reserved especially for you. Therefore, it is of utmost importance that you are on time. If you are more than ten minutes late for your scheduled appointment, we reserve the right to reschedule you to another day and/or time. Rushing through dental treatment because of patient tardiness can compromise the results of that treatment, and is unacceptable to our dental team, and most importantly, to you!

In addition, our office must be notified if you will be unable to keep a scheduled appointment. For your convenience, you may call the office 24 hours a day, seven days a week to leave a message. Cancellations must be made at least 48 hours before your appointment. This gives us adequate time to call and appoint other patients needing treatment. If you cancel your appointment without giving at least 24 hours notice, or if you fail to keep an appointment without giving our office any notification two times within the course of one year, it will be necessary for you to seek dental treatment at another dental office of your choosing.

Again, we would like to thank you for allowing us to serve your dental needs. We value and appreciate you as a patient and as an individual. If we can do anything to make your experience here more enjoyable and relaxing, please do not hesitate in informing us.

Thank you for your cooperation.

Sincerely,

Dr. Jason, Dr. Chasity, and staff

Child Medical History

Date: _____

Patient:_____ **Birthdate:** _____/_____/_____
LAST **FIRST** **MIDDLE**

Does your child: (Please circle one)

YES **NO** Have a current physician?

Physican: _____ Phone # _____

YES **NO** Take ANY prescription / non-prescription medication(s) or dietary / herbal supplement(s)?
If yes, please list all, including reason why.

_____

_____

YES **NO** Have any allergies to ANY medications or food products? If yes, please list.

_____

YES **NO** Have an allergy to latex products?

YES **NO** Require antibiotics prior to dental treatment due to heart murmur, shunt, prosthetic devices, history of rheumatic fever, etc.?

YES **NO** Have any prosthetics? Example: artificial limbs, prosthetic eye, pins, screws, etc.

Female patients:

YES **NO** Currently taking oral contraceptives?
YES **NO** Pregnant? Is so when is she due? _____/_____/_____ Name of OB: _____
YES **NO** Nursing?

Do you consider your child to be: (please check one)

_____ Advanced in the learning process
_____ Progressing normally
_____ Slow in the learning process

Please Circle "YES" or "NO" As It Relates To Your Child's Health

YES	**NO**	Heart Murmur / Heart Problems	**YES**	**NO**	HIV positive / AIDS
YES	**NO**	Shunts	**YES**	**NO**	Hemophilia / Bleeding problems / Anemia
YES	**NO**	Cancer	**YES**	**NO**	Hearing Impairment
YES	**NO**	Diabetes	**YES**	**NO**	Speech Issues
YES	**NO**	Rheumatic Fever	**YES**	**NO**	Hyperactive /ADD / ADHD
YES	**NO**	Liver problem / Hepatitis	**YES**	**NO**	Frequent Headaches
YES	**NO**	Kidney Disease	**YES**	**NO**	Asthma Last Attack_____
YES	**NO**	Convulsions / Epilepsy / Seizures	**YES**	**NO**	Physical / Mental Impairment
YES	**NO**	Autism	**YES**	**NO**	Dermatologic or Skin Conditions

YES **NO** Learning Disability / Developmental Delay

YES **NO** Any hospital stay / operations Please List:_____

YES **NO** Are there any other medical conditions or problems relating to your child? If yes, please list:

_____

_____
Doctor's Signature Date

Child Oral Health Questionnaire

Date: _____

Patient:_____ **Birthdate:** _____/_____/_____
LAST **FIRST** **MIDDLE**

Completed by: _____ Relationship to Patient: _____

Diet and Nutrition

(Please circle one)

Does your child sleep with a bottle? **YES** **NO**
How many times does your child have:
Something to drink each day? _____ Snacks each day?_____
Is your child on a special diet? **YES** **NO**

Fluoride Use

What is your child's main source of water (well, tap, bottle, etc.)?_____
Do you use fluoride toothpaste for your child? **YES** **NO** _____
Do you use fluoride rinse or another other forms of fluoride? **YES** **NO** _____

Oral Habits

Does your child use a pacifier? **YES** **NO**
Does your child suck a thumb or fingers? **YES** **NO**
Does your child grind his/her teeth day or night? **YES** **NO**
Does your child use tobacco products? **YES** **NO**
Does your child use alcohol or drugs? **YES** **NO**

Injury Prevention

Does your child play sports? **YES** **NO**
Has your child had an injury to his/her mouth? **YES** **NO**
If so when and please describe nature of injury_____

Oral Development and Dental History

Child's age (in months) when the first tooth came in? _____
Have you noticed any problems with your child's mouth or teeth? _____
Does your child complain of mouth pain? _____ If so for how long? _____
Has anyone in your family had extra or missing teeth? **YES** **NO**

Oral Hygiene

How often does your child brush each day? _____ Floss? _____
Do you help your child brush? **YES** **NO** Floss? **YES** **NO**

Patient Information

Date: _____

Patient:_____ **Birthdate:** _____/_____/_____

LAST **FIRST** **MIDDLE**

Preferred Name: _____ Gender: Male Female

Have we seen another family member in your family? _____ If yes, whom? _____

Who may we thank for referring you to our office? _____

Who has legal guardianship of this child? _____

Name(s) / Relationship(s)

Who does this child currently live with? _____

Name(s) / Relationship(s)

Who brought this child today? _____

Name(s) / Relationship(s)

Who is responsible for making appointments?_____Best phone # to be reached at_____

We would like to know a little about your child and what he/she likes: Pet's name: _____

Favorite character: _____ Favorite Hobbies / Sports: _____

Grade: _____ School attending: _____

Emergency Information

Name of nearest relative/friend not living with you_____Relationship _____

Complete address _____ Phone _____

Dental History

What is your main concern for this visit? _____

Does your child have any dental problems that you are aware of? If yes, explain: _____

_____

Has your child: (Please circle one)

YES NO Ever visited the dentist before? Date of last visit? _____Were x-rays taken? _____

Previous dentist's name: _____ Location: _____

YES NO Ever had an unfavorable dental / medical visit? If yes, explain: _____

_____

Please sign below:

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 child's health. I also understand that it is my responsibility to inform this office of any changes in my child's medical status, address, phone number, email address or any other personal information. I give All About Smiles Dentistry, P.C. permission to perform a cleaning, x-rays, exam, fluoride treatment, sealants, or emergency treatment for my child.

_____ _____ _____

Signature Date Relationship to Child

Responsible Party Information

Date: _____

Patient:_____ **Birthdate: ____/____/_____**
LAST **FIRST** **MIDDLE**

PATIENT SOCIAL SECURITY # _____-_____-_____ **PATIENT CELL# _____**
(Only used for confirmation purposes)

MOTHER / LEGAL GUARDIAN (Please Circle) Name _____
LAST FIRST MIDDLE

Address_____
STREET/PO BOX CITY STATE ZIP

Date of Birth _____/_____/_____ Social Security # _____-____-_____ E-mail _____

Home# _____ Cell# _____ Work# _____

Place of Employment _____ Occupation _____

Name of Spouse (if different than Father/Legal Guardian)_____

FATHER / LEGAL GUARDIAN (Please Circle) Name _____
LAST FIRST MIDDLE

Address _____
STREET/PO BOX CITY STATE ZIP

Date of Birth _____/_____/_____ Social Security# _____-____-_____ E-mail_____

Home# _____ Cell# _____ Work# _____

Place of Employment _____ Occupation _____

Name of Spouse (if different than Mother/Legal Guardian) _____

Insurance Information

Is the patient covered by (please circle): Dental Insurance or Medicaid? If covered by dental insurance complete the following:

Primary Insured's Name_____
LAST FIRST MIDDLE

Social Security/ID# _____ Date of Birth ___/___/ ____ Relationship to Patient_____

Insurance Company_____Phone #_____ Employer _____Group# _____

Secondary Insured's Name_____
LAST FIRST MIDDLE

Social Security/ID# _____ Date of Birth ___/___/ ____ Relationship to Patient_____

Insurance Company_____Phone #_____ Employer _____Group# _____

Please Initial Below:

_____By signing this form, I agree to take full financial responsibility for this child's account independent of what a divorce decree may state. If dental insurance is applicable, I understand that my estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is payable by me within 30 days. I understand that a FINANCE CHARGE with an Annual Percentage Rate of 18% will be imposed on any account balance 60 days or more outstanding.

_____I hereby authorize payment of dental insurance benefits, if any, to be made directly to All About Smiles Dentistry, P.C.

Signature of person completing form_____ Date_____

Printed Name _____ Relationship to Patient _____

AUTHORIZATION FOR TREATMENT OF A MINOR

I, _____, parent(s)/legal guardian(s) of:

_____, a minor child born on _____/_____/_____,

_____, a minor child born on _____/_____/_____,

_____, a minor child born on _____/_____/_____,

_____, a minor child born on _____/_____/_____,

_____, a minor child born on _____/_____/_____,

_____, a minor child born on _____/_____/_____.

Hereby authorize other than legal parent/guardian:

_____ _____

(Name) (Relationship to child) (Name) (Relationship to child)

_____ _____

(Name) (Relationship to child) (Name) (Relationship to child)

to give consent for the dental treatment of the above named child(ren) for any dental condition that he/she may encounter; or to bring the child(ren) to AAS for routine checkups and associated procedures deemed necessary by AAS. I also authorize the dentist, hygienists, and staff at AAS to give information to the individual(s) named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child(ren).

- I hereby release AAS of any liability regarding release of this information on the above named child(ren).
- I understand that if someone other than the above listed on this form brings my child(ren) to the dental appointment, my appointment will be rescheduled for another time.
- I understand that only the above listed have permission to make decisions regarding my child(ren)'s dental treatment, and it is my or other legal guardian's responsibility to notify AAS of any desired changes.
- I understand that the above listed will stay in effect until otherwise notified by myself or other legal guardian.
- I understand that even though I have authorized the above named to make treatment decisions regarding the above named child(ren), I will be financially responsible for this family account.

_____ _____ _____

Parent/Legal guardian Date Parent/Legal guardian Date

Please INITIAL if applicable:

_____I hereby authorize my child (ages 16 and above) to receive dental treatment (e.g. dental checkup, emergency visits, x-rays, cleaning, fluoride) without an authorized person accompanying him/her.

ALL ABOUT Smiles DENTISTRY

Office Financial Options

It is our goal to make financing of dentistry comfortable for all of our patients families. We realize that dentistry may be costly. We feel the following options will meet the needs of most of our patients.

1. Payment by appointment. (This options lets you spread out your payments according to your treatment plan.)
2. MasterCard, Visa, American Express or Discover
3. 3 to 18 month interest free or extended financing through Care Credit. (Please see our business team for further information.)
4. A 10% reduction in your fees if there is no insurance to file.

If payment goes past due we reserve the right to add reasonable & customary fees for collection or attorney fees.

With Regards to Insurance Benefits

- Insurance benefits are designed to cover some, but not all, of your dental services. We will be happy to submit your services to your insurance company as long as you have provided us the appropriate information prior to services being rendered.
- Insurance is not meant to be a "pay all". Please know that most always there will be a co-payment due at the time of each service.
- Most insurance companies let you choose your own dentist. All insurance companies have their own fee schedules. These fees are not always the same as the fee your dentist charges for the same services.

  Example – if your dental insurance company states they allow two FREE cleanings a year; what they mean is they will pay up to 100% of THEIR fee for a cleaning, exam and x-rays. Meaning, if your dentist charges $70.00 for a "cleaning" and your dental insurance fee schedule states that they pay 100% BUT their fee is $60.00; the patient ends up owing their dentist an additional $10.00 because of the difference in the fee schedule of the dental insurance vs. the dental office.
- **You are responsible for all differences in the fees between the insurance company and the dental office, unless your dentist has a contract with your specific dental insurance company to accept the fees that the insurance dictates.**

Our doctors HAVE CONTRACTS with the following insurance companies:

1. Delta Dental of Oklahoma – **Premiere provider only**
2. Blue Cross Blue Shield of **Oklahoma**
3. Cigna – **Radius Network only**
4. Health Choice – **aka STATE Insurance**

We will bill ALL insurance companies for payment. If, however, your insurance is not one of the companies listed above, there MIGHT be a difference in fees, **in addition to your copay,** that you would be responsible for. We strive to give our patients our best GUESS and will always submit for a written authorization from your insurance company for any treatment recommendations above $500 so you, as the patient, will have minimal surprises as to what your out of pocket cost is after your insurance company pays.

I have read and understood the above statements.

_____ _____

Signature **Date**

724 N. Washington Ave • P.O. Box 1637 • Durant, Oklahoma 74702 • 580-924-0660 • Fax 580.924.5376

ALL ABOUT SMILES DENTISTRY
JASON CARPER DDS
CHASITY CARPER DDS
724 North Washington Avenue
Durant, Oklahoma 74702
580-924-0660

Patient Name: _____ Date: _____

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for All About Smiles Dentistry.
- I may refuse to sign.
- Expiration: 3 years from initial/last signature; insurance change; patient reaches age of 18.

- I understand that I may request a copy of the privacy policies at any time.
- 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.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION AND INFORMATION ABOUT MY DENTAL HEALTH** VIA:

- ☐ Message on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ Any of the above

_____ _____

Please ***print*** your name Please ***sign*** your name

☐ Patient ☐ Parent ☐ Guardian ☐Other:_____