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

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

ALL ABOUT Smiles DENTISTRY

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

All About Smiles 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.

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

PATIENT MEDICAL HISTORY

Name: _____ **Date of birth:** _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❑Yes ❑No If yes, Specify:
_____

Have you ever been hospitalized or had a major operation? ❑Yes ❑No If yes, Specify:
_____

Have you ever had a serious head or neck injury? ❑Yes ❑No If yes, Specify:
_____

Are you taking any medications, pills, or drugs? ❑Yes ❑No If yes, Specify:
_____
_____
_____

Do you take, or have you taken, Phen-Fen or Redux? ❑Yes ❑No If yes, Specify:
_____

Do you use tobacco? ❑Yes ❑No If yes, Specify:
_____

Do you use controlled substances? ❑Yes ❑No If yes, Specify:
_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑Yes ❑No

Do You Snore? / Trouble Sleeping? / Tired During the Day? / Restless Leg Syndrome/ Use CPAP? ❑Yes ❑No

Women:	Are you Pregnant/Trying to get pregnant?	❑Yes ❑No
	Taking oral contraceptives?	❑Yes ❑No
	Nursing?	❑Yes ❑No

***Are you allergic to any of the following?**

❑Aspirin ❑Penicillin ❑Codeine ❑Local Anesthetics ❑Acrylic ❑Metal

❑Latex ❑Sulfa Drugs ❑Other If yes, explain: _____

***Are you required to pre-medicate with antibiotics before dental treatment? ❑Yes ❑No**

If answer was yes for premed, please list reason why: _____

PREFERRED PHARMACY:_____

PATIENT MEDICAL HISTORY

Do you have, or have you had, any of the following:

Aids/HIV Positive	❑Yes	❑No	Hepatitis A	❑Yes	❑No
Alzheimer's Disease	❑Yes	❑No	Hepatitis B or C	❑Yes	❑No
Anaphylaxis	❑Yes	❑No	Herpes	❑Yes	❑No
Anemia	❑Yes	❑No	High Blood Pressure	❑Yes	❑No
Angina	❑Yes	❑No	High Cholesterol	❑Yes	❑No
Arthritis/Gout	❑Yes	❑No	Hives or Rash	❑Yes	❑No
Artificial Heart Valve	❑Yes	❑No	Hypoglycemia	❑Yes	❑No
Artificial Joint	❑Yes	❑No	Irregular Heartbeat	❑Yes	❑No
Asthma	❑Yes	❑No	Joint replacement or implant	❑Yes	❑No
Blood Disease	❑Yes	❑No	Kidney Problems	❑Yes	❑No
Blood Transfusion	❑Yes	❑No	Leukemia	❑Yes	❑No
Breathing Problem	❑Yes	❑No	Liver Disease	❑Yes	❑No
Bruise Easily	❑Yes	❑No	Low Blood Pressure	❑Yes	❑No
Cancer	❑Yes	❑No	Lung Disease	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No
Chest Pains	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Cortisone Medicine	❑Yes	❑No	Pain in Jaw Joints	❑Yes	❑No
Cold Sores/Fever Blisters	❑Yes	❑No	Parathyroid Disease	❑Yes	❑No
Congenital Heart Disorder	❑Yes	❑No	Psychiatric Care	❑Yes	❑No
Convulsions	❑Yes	❑No	Radiation Treatment	❑Yes	❑No
Diabetes	❑Yes	❑No	Recent Weight Loss	❑Yes	❑No
Drug Addiction	❑Yes	❑No	Renal Dialysis	❑Yes	❑No
Easily Winded	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No
Emphysema	❑Yes	❑No	Rheumatism	❑Yes	❑No
Epilepsy	❑Yes	❑No	Scarlet Fever	❑Yes	❑No
Excessive Bleeding	❑Yes	❑No	Seizures	❑Yes	❑No
Fainting Spells/Dizziness	❑Yes	❑No	Sinus Trouble	❑Yes	❑No
Frequent Cough	❑Yes	❑No	Spina Bifida	❑Yes	❑No
Frequent Diarrhea	❑Yes	❑No	Stomach/Intestinal Disease	❑Yes	❑No
Frequent Headaches	❑Yes	❑No	Stroke	❑Yes	❑No
Genital Herpes	❑Yes	❑No	Swelling of Limbs	❑Yes	❑No
Glaucoma	❑Yes	❑No	Thyroid Disease	❑Yes	❑No
Hay Fever	❑Yes	❑No	Tonsillitis	❑Yes	❑No
Heart Attack/Failure	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Heart Murmur	❑Yes	❑No	Tumors or Growths	❑Yes	❑No
Heart Pace Maker	❑Yes	❑No	Ulcers	❑Yes	❑No
Heart Trouble/Disease	❑Yes	❑No	Venereal Disease	❑Yes	❑No
Hemophilia	❑Yes	❑No			

Have you ever had any serious illness not listed above? ❑Yes ❑No

If yes, please explain:

_____

_____

▪ I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print Name_____ **Signature** _____

Date_____ **❑Adult Patient ❑Parent or Guardian ❑Spouse**

Doctor Signature _____**Date**_____

PATIENT DENTAL HISTORY

Name: _____ **Date:** _____

Date of birth: _____ Date of last dental exam: _____

Reason for this visit? _____

Previous dentist? _____

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed while brushing or flossing?	☐Yes ☐No
Are your teeth sensitive to hot or cold liquids/foods?	☐Yes ☐No
Are your teeth sensitive to sweet or sour liquids/foods?	☐Yes ☐No
Do you feel pain to any of your teeth?	☐Yes ☐No
Do you have any sores or lumps in or near your mouth?	☐Yes ☐No
Have you had any head, neck or jaw injuries?	☐Yes ☐No
Have you ever experienced any of the following problems in your jaw?	
Clicking	☐Yes ☐No
Pain (joint, ear, side of face)	☐Yes ☐No
Difficulty in opening or closing	☐Yes ☐No
Difficulty in chewing	☐Yes ☐No
Do you have frequent headaches?	☐Yes ☐No
Do you clench or grind your teeth?	☐Yes ☐No
Do you bite your lips or cheeks frequently?	☐Yes ☐No
Have you noticed any loosening of your teeth?	☐Yes ☐No
Does food tend to become caught between your teeth?	☐Yes ☐No
Have you ever had periodontal treatment (gums)?	☐Yes ☐No
Ever worn a bite plate or other appliance?	☐Yes ☐No
Have you ever had any difficult extractions in the past?	☐Yes ☐No
Have you ever had any prolonged bleeding following extractions?	☐Yes ☐No

Do you wear dentures or partials? ☐Yes ☐No If yes, date of placement _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐Yes ☐No

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

_____

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 examination rendered to me or my child during the period of such dental care o third party payros and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. 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 service rendered on my behalf of my dependents.

_____ _____

Signature of Patient or Parent/Guardian if Minor Date

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0515787/270000

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

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:_____