PRAIRIE DENTAL GROUP

Bryan C. Bumpas D.D.S.

Dear Valued Patient,

We understand that choosing a new dentist and dental health team can be a challenge, leaving you feeling somewhat uncertain. Let us welcome you and share some insights about what we do for our patients. The philosophy guiding our practice is as follows:

> **"Our purpose is to produce happy, smiling patients. We treat every patient as a special person with sincerity and respect, always striving to provide an excellent dental experience."**

In other words, we help you be or become as healthy as you choose. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are five levels on which people may choose to be seen in our practice. Please check the level of care you feel most appropriate for you at this time.

___ **Level 1… Urgent Care**
People in crisis or with an emergency problem such as pain, swelling or bleeding that need our immediate help. We see emergencies immediately whenever possible.

___ **Level 2… Remedial Care**
People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally at this level people expect a limited type of examination, focusing on obvious problems. They usually want to correct immediate problems with as little effort or cost as possible.

___ **Level 3… Self-Care**
People who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose repair solutions that are short range in nature.

___ **Level 4… Complete Dentistry**
People at this level are similar to people described in level 3. They choose to have a thorough examination. However, they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all the dental treatments provided to be completed in the most lasting fashion as possible.

___ **Level 5… Look Your Best**
People in this group are similar to people described in level 4, but also want to look their best at all times. They know that their smile is the first thing others notice about them and want to put their best smile forward.

It is not uncommon for people to begin at one level and progress to another over time. We are here to help you discover and decide at what level you are most comfortable.

Thank you for the opportunity to serve you and provide you with the best dentistry appropriate for you.

PATIENT INFORMATION

Patient's name ______________________ Preferred name ______________ Birth date__________

If minor, parent/guardian names ______________________ Home phone ____________ Work phone ____________

Mobile phone __________ E-Mail ______________________________

Mailing address ______________________________ City ______________State _______ Zip __________

Employer ______________________ Occupation ______________________________

SSN ______________

Spouse's name ______________________ Spouse's employer ______________________ ❑ Unmarried

Whom may we thank for referring you to our office? ______________________________ ❑ Phonebook

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:______________________________

Women:

- ❑ May be pregnant
  Expected delivery date: ____________
- ❑ Taking hormones or contraceptives

Name of your physician:______________________________

Do you have any disease, condition, or problem not listed above?______________________________

Signature of Patient/Guardian. Date

DENTAL HISTORY AND CONSENT FOR TREATMENT

Reason for seeking dental care at this time ______________________________

Date of last dental visit __________ Reason? ____________________ Date of last X-rays __________

Former dentist ____________________ City/state ____________________

How often do you: **Brush** ______ times per __________ **Floss** ______ times per __________

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

☐Aching or sensitive teeth	☐Broken filling	☐Areas of food traps	☐Unfavorable dental experience
☐Sensitive or bleeding gums	☐Loose teeth	☐Difficulty opening wide	☐Growths or lesions in your mouth
☐Broken or missing teeth	☐Bad breath	☐Clicking or popping in jaw	☐Cold sores
☐Grinding or clenching	☐Swollen glands	☐Jaw pain or tiredness	☐Dry mouth
☐Swelling or lumps in mouth	☐Gum infection	☐Orthodontic treatment	☐Other __________

If you could change your smile, what would you change?

☐Remove unsightly fillings	☐Straighten teeth	☐Change shape of teeth	☐Close gaps between teeth
☐Replace missing teeth	☐Whitening	☐Make teeth same color	☐Other __________

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

______________________________	______________	______________
Signature of patient or authorized responsible party	Relationship	Date

Primary insurance

Insured's name ____________________

Insurance company ____________________

Address ____________________

____

Phone ____________________

Union or Local # ____________________

Group ____________________

Employer ____________________

Social Security # ____________________

Secondary insurance

Insured's name ____________________

Insurance company ____________________

Address ____________________

____

Phone ____________________

Union or Local # ____________________

Group ____________________

Employer ____________________

Social Security # ____________________

Insurance agreement

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

____________________ ____________________

Signature of responsible party Date

Financial Policy

We are committed to providing you the best possible care. If you have dental insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will be happy to process your claim for reimbursement. If we accept assignment of your insurance plan, you will only be required to pay an **estimated co-pay and deductible** or percentage as stated by your insurance company. Payment for these **estimated charges** is expected on your date of service and is payable by Visa, MasterCard, Discover, check or cash.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company and we are not a party of that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We will have no way of knowing how your insurance policy is written. All are different.
3. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "Usual & Customary" charges etc., other than to supply factual information as necessary.

We must emphasize that as a dental provider, our relationship is with you, the patient and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. I understand that if my insurance company fails to pay within 60 days of the claim being submitted, the full amount due is my responsibility and I will make payment in full.

A finance charge of $30.00 will be applied to all unpaid previous month's balance(s) on all accounts that are thirty (30) days past due or an insufficient returned check.
Should your account default, you will be responsible for any and all charges related to being submitted to our collections company, American Profit Collection's.

If you have any questions regarding the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient's Name Printed: ______________________________________

Patient's Signature: ____
Date: ____

We notice you have insurance.

Did your insurance company examine your oral health before giving you the plan?

- They didn't? I'm not surprised.

Only one kind of true insurance is guaranteed, and that's life insurance.

- For that, you get an exam!

All other forms of insurance are a limited payout based on the terms and conditions of your plan.

- Nothing to do with your mouth.

Let us tell you how insurance works.

- In 1967, the annual limit was $1,000. The would be nearly $7,000 today.
- So, in a five year period, you could still get well over $30,000 in treatment completed.
- Today, the annual limit is approximately $1,500… so it is impossible to get everything you need paid by insurance.

We promise you, we will never be guided by your insurance plan.

- Let's talk first about what dentistry you need, then how you can pay for it.

Insurance is a method of payment, not a method of treatment.

- We're always going to look out for your best interests first.

________________________________ date ________________

Signature

Notice of Privacy Practices Acknowledgement
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

SECTION B: We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Prairie Dental
1200 NW 192nd St
Edmond, OK 73012
405-282-6444

SECTION C: Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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 if you revoke this Consent.

SECTION D: I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may in involved in that treatment directly and indirectly
- Obtain payment from third-part payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received and read and do understand your Notice of Privacy Practices containing a more complete description of the uses of disclosures of my health information. I understand that this organization has the right to change its' Notice of Privacy Policy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Prairie Dental
Notice of Privacy Practices Acknowledgement
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
SIGNATURE PAGE

PATIENT NAME:____

DATE:____________________

SIGNATURE AND ACKNOWLEDGEMENT

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health Information to carry out treatment, payment, payment activities and health care operations only. I also acknowledge receipt of the Notice of Privacy Practices from **Prairie Dental,** I have been offered a copy of this notice of privacy practices.

Please check one of the following:

☐ I authorize the following person to have complete access to my dental and health records which may include financial information, radiographs, clinical notes, treatment plans, and health history.

Name: ______________________________

Contact number: ________________________

Relationship to patient: _________________________

☐ I do not authorize the release of any information to any individual at this time.

____________________________________ ____________________________

Signature **Date**

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: __________________________

Relationship to Patient:__________________

FOR 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 barrier
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_________________________

Cancellation Policy

We ask for at least 24 hours advance notice for canceling or rescheduling a **reserved** appointment. Patients who fail 3 appointments may be subject to "same day" appointments only.

For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people- the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

_______________________________________ ____________

Signature Date