DDS DENTURES+IMPLANT SOLUTIONS

Welcome to DDS and thank you for trusting us to delight you with our dental care!

First Name: _____ Last Name: _____

Middle Initial: _____ Preferred Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Gender: □ Male □ Female □ Other

Marital Status: □ Married □ Divorced □ Single □ Widowed Date Of Birth: _____/_____/_____

Social Security: _____ E-Mail: _____

Emergency Contact: _____ Contact Phone: _____

Employer: _____ General purpose of your visit: _____

How did you first hear about us (check one)?: □ Friend/Family □ TV □ Drive-By □ Newspaper/Mail □ Internet

□ Billboard □ Phonebook □ Other _____

If a friend or family member referred you, whom may we thank?: _____

* Please Continue This Form Only If You Have Insurance *

Primary Insurance information

Insurance Company: _____

Policy Holder Name: _____Social Security: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Employer: _____

Relationship to Patient: □ Self □ Spouse □ Child □ Other _____

Secondary Insurance information

Insurance Company: _____

Policy Holder Name: _____Social Security: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Employer: _____

Relationship to Patient: □ Self □ Spouse □ Child □ Other _____

Patient's Printed Name: _____ **MEDICAL HISTORY**

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body of course. Therefore, health problems that you may have, or substances that you may be ingesting are very likely to have an important interrelationship with the dental services you will receive. Thank you for answering the following questions.

Are you under a physician's care now and/or do you have sleep apnea?	❍Yes ❍No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	❍Yes ❍No	If yes, please explain: _____
Have you ever had a problem with tooth extractions of any kind?	❍Yes ❍No	If yes, please explain: _____
Have you ever had a serious head/neck injury or head/neck radiation?	❍Yes ❍No	If yes, please explain: _____
Are you taking any medications, health supplements or controlled substances?	❍Yes ❍No	If yes, please explain: _____
Have you ever taken Phen-Fen or Redux (prescribed for weight loss usually)?	❍Yes ❍No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel, Reclast, Zometa, Prolia or any other medications called bisphosphonates (prescribed for osteoporosis usually)?	❍Yes ❍No	If yes, please explain: _____
Have you ever taken blood thinners including but not limited to aspirin, Coumadin or Plavix?	❍Yes ❍No	If yes, please explain: _____
Have you ever taken Selective Serotonin Re-Uptake Inhibitors (SSRIs) for depression or otherwise?	❍Yes ❍No	If yes, please explain: _____
Do you use tobacco in any form (smoking/e-vape, chew, pouches, etc.)?	❍Yes ❍No	If yes, please explain: _____
Do you have diabetes or are you on any special diet of any kind?	❍Yes ❍No	If yes, please explain: _____
Do you currently wear a full or partial denture? If you answered yes, please tell us how old it is.	❍Yes ❍No	If yes, please explain: _____

Women: Are you? ❍ Pregnant/Trying to get pregnant ❍ Nursing ❍ Taking oral contraceptives

Are you allergic to any of the following? ❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic

❍ Other _____ ❍ Metal ❍ Latex ❍ Sulfa Drugs ❍ Local Anesthetics

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

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

Have you ever had an illness not listed above? If yes, please explain: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: X **Date:**

Financial Understanding Agreement

_____
Patient's Printed Name

Thank you for choosing our office. We appreciate you. We want to delight you with our service. Part of our service must deal with communicating your financial responsibilities. That is the purpose of this form.

PAYMENT AND INSURANCE IN GENERAL
Professional services are rendered on a cash or cash equivalent basis only and payment is due in full at the time services are rendered. Debit and most credit cards are accepted. With approved credit, patients may be eligible for third-party financing which entitles patients to a revolving charge account upon approval of the application. **We file most major insurance forms with the understanding that you, the Patient, assign your rights to the insurance benefits to us in full but we require that patients pay their estimated amount towards the total cost at the start of treatment**. Please remember that all professional services are rendered to the patient and not to the insurance company. **The patient is ultimately responsible for the total charges regardless of insurance filing or insurance company involvement.**

CERTAIN INSURANCE PATIENTS
I understand that I may elect to purchase a denture(s) or other enhanced category of dental services that is priced above what my insurance will bear. I agree to pay $_____ out of my own pocket since my insurance will only cover $ _____ of my denture(s) or other enhanced category of dental services. I want the enhanced value (warranty/tooth upgrade) associated with the enhanced offering and I am willing to pay out of my pocket for it.

_____
Patient Initials

HALF (1/2) DOWN PAYMENT, IF APPLICABLE
I, the Patient, understand that if the services rendered to me consist of partial dentures or crowns / bridges (and full dentures too in certain longer term scenarios) then I will be **required to pay half (1/2) of the total unit price for each item at the time of impression**. For example, if I am scheduled to get a seven hundred dollar ($700.00) crown, I will pay three hundred and fifty dollars ($350.00) at the time an impression is taken in my mouth. From that impression, my actual crown will be made. The same policy applies for the other services listed above.

The half (1/2) payment serves to help cover some of the costs of the impression taking and the crown or other dental prosthetic creation time (labor), materials, and overhead. **This amount is what I will pay at the impression taking time regardless of any insurance coverage I have.** Should I fail to return for the placement of the crown or other item (e.g. partial denture, bridge or full denture), then I realize and agree that the half (1/2) payment shall serve as a payment in full for the costs mentioned in the paragraph above and that I shall have no claim to the return of that money.

If my return for the final crown or other item seating is delayed by me, I understand that the fit might not be adequate any longer as structures in my mouth can shift over time. In such a case, I might have to pay for new impressions to be made or for a new dental appliance to be made or both. In that case, I will have to pay half (1/2) of the total price again for each new item at the time of impression**. If I return as scheduled, I will receive my crown or other item(s) and I shall at that time owe the other half (1/2) payment whether by cash, credit card, check (if allowed), third-party financing (if pre-approved or insurance).**

BAD CHECK FEE AND NO SHOW
At the office's sole discretion, the office may assess a bad check fee of twenty-five dollars ($25.00) for any check that is returned for insufficient fund (NSF) or for stop payment or which is returned unpaid for any other reason. The office may assess a no show fee of fifty dollars ($50.00) for any appointment that is scheduled but missed by a patient for reasons other than the office's closure for weather.

_____ _____
Signature of Patient or Patient's Legal Guardian Date of Signature

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this health-care facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please **print** name of Patient **Signature** of Patient or Patient's Legal Guardian

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

We will address you by your first name unless you specify otherwise. If you prefer to be summoned from the reception area by a different name please indicate here:

□ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouses, friends, relatives and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

I authorize this office to contact me in order to confirm my appointments, advise of special services, treatment and billing information.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____ _____

Signature of Privacy Officer

NOTICE OF PRIVACY PRACTICES

DDS Dentures+Implant Solutions

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED AND HOW THE PATIENT CAN GET ACCESS TO THIS HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF HEALTH INFORMATION OF THE PATIENT IS IMPORTANT TO US. THIS NOTICE IS TO BE GIVEN TO THE PATIENT AND THE PATIENT MAY KEEP IT.

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 your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1-1-03 (January 1, 2003), and will remain in effect until we replace it.

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 of 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 DISCLOSURE 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 providing treatment to you. This includes the transmission of your health information to third-party laboratories as needed to create dental prostheses or perform tests on your behalf.

Payment: We may use and disclose your health information to obtain payment (such as from insurance providers) for services we provide to you.

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, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization (see our office for the appropriate release form) to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us 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, but 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. If 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 the person's involvement in your healthcare. We will also use our professional judgment 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-Related Services: We will not sell or disclose your health information for third-party marketing communications without your written authorization. We may offer you internal promotions and marketing communications which may be facilitated by an outside service like RevenueWell, etc. (but you may opt out).

Required by Law: We may use or disclose your health information when we are required to do so by law.

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 authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We

may disclose to correctional institution or law enforcement official having lawful custody of protected health information of an 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

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. **You must make a request in writing to obtain access to your health information. You may obtain a form to request access by asking this office for the appropriate release form. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you a reasonable amount for each page, plus postage costs, if applicable. If your record contains any item that requires a photographic process to copy, such as an x-ray or photograph, we may charge you up to $5.00 per image.** If you request an alternative format, we will charge a cost-based fee for providing your health information in that format assuming your request can practicably be complied with by us. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our applicable business associates disclosed your health information for purposes, 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 twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to the 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 location, and provide satisfactory explanation about how payments will be handled 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 and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website (www.dentalservice.net) or by electronic mail (e-mail), you are entitled to receive this Notice in written form if you so request in writing.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact the Privacy Policy Administrators below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact the Privacy Policy Administrators 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 to 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.

PRIVACY POLICY ADMINISTRATOR:

SEAN MALLOY

FAX: 918-473-8100

ADDRESS:

HIPAA PRIVACY POLICY ADMINISTRATION

ATTN.: SEAN MALLOY

P.O. BOX 328

CHECOTAH, OK 74426