PATIENT INFORMATION

NAME:_____PREFERRED NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP_____

PHONE (_____)_____WORK PHONE (_____)_____CELL PHONE(_____)_____

DATE OF BIRTH:_____SOCIAL SECURITY NUMBER:_____

CIRCLE APPROPRIATE STATUS: MINOR SINGLE MARRIED WIDOWED SEPARATED DIVORCED

IF STUDENT, NAME OF SCHOOL:_____ FULL TIME/PART TIME

SPOUSE OR PARENTS NAME:_____EMPLOYER_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

EMERGENCY CONTACT_____PHONE(_____)_____

EMAIL ADDRESS WOULD YOU LIKE TO RECEIVE EMAIL CONFIRMATION? YES / NO

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT (CIRCLE ONE): SELF SPOUSE PARENT OTHER

NAME:_____SOCIAL SECURITY NUMBER:_____

ADDRESSS:_____CITY:_____STATE:_____ZIP:_____

PHONE(_____)_____EMPLOYER:_____WORK PHONE(___)_____

INSURANCE INFORMATION

NAME OF INSURED:_____DOB:_____RELATIONSHIP TO PATIENT:_____

SOCIAL SECURITY NUMBER:_____NAME OF EMPLOYER:_____WORK#:(___)_____

ADDRESS OF EMPLOYER:_____CITY:_____STATE:_____ZIP:_____

INSURANCE COMPANY:_____GROUP#_____ID#_____

INSURANCE COMPANY ADDRESS:_____CITY:_____STATE:_____ZIP:_____

INSURANCE COMPANY PHONE NUMBER:_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO

NAME OF INSURED:_____DOB:_____RELATIONSHIP TO PATIENT:_____

SOCIAL SECURITY NUMBER:_____NAME OF EMPLOYER:_____WORK#:(___)_____

ADDRESS OF EMPLOYER:_____CITY:_____STATE:_____ZIP:_____

INSURANCE COMPANY:_____GROUP#_____ID#_____

Time 12:17 PM

Divine Dental Works

Date 1/9/2020

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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 ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or 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	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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:_____

Informed Consent for General Treatment

All dental and anesthetic procedures have associated risk. These may be, but are not limited to:

- Drug reactions, side effects and/or reactions to anesthetic that are possibly life threatening and necessitate emergency care
- A blood filled swelling called a hematoma, that can form when a needle, used during an injection, hits a blood vessel
- During a "filling" preparation, the effects of decay and the removal of the decay may cause a nerve in the middle of the tooth to be exposed or damaged. This may require the tooth to have a root canal therapy and a subsequent crown or full coverage restoration. In severe cases, tooth extraction may be required
- Fractures of restorations or recurrent decay may occur after placement. This may be corrected with a new filling or require a crown
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that may require additional treatment
- Delayed healing of an extraction site (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date
- Remainder of a root tip that may necessitate additional care or referral to a specialist
- Involvement of the nerves during the removal of teeth, anesthetic administration, tooth preparation resulting in the temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, pain and/or restricted jaw opening that may persist for several days or longer
- Failure of the dental procedure necessitating additional treatment, retreatment or extraction
- Breakage of dental instruments or perforation inside the dental canal making additional dental treatment necessary, referral to a specialist, or loss of tooth
- Complications during treatment including fracture or dislocation of jaw necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered guarantees.

Patient Name: **Print Patient/Guardian Name:**

Sign:

Date:

Doctor Signature:

Witness Signature:

Divine Dental Works
TRISCHA CLARKE, DDS

Insurance and Financial Policy

At **Divine Dental Works**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know.....

Your dental benefits are based upon a contract made between your employer and an insurance company. We will always **recommend** treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like a more accurate insurance estimation of your benefits, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you a closer estimation of your out of pocket figures you may require. This does not mean your insurance company is guaranteed to pay that exact amount.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."**

We bill your insurance as a courtesy. If insurance does not pay within 60 days, **Divine Dental Works** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. You are responsible for our office fee and not your insurance negotiated rate if your insurance company denies your claim. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Divine Dental Works does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash, and checks (for existing patients with established payment history). We **do not accept** checks for over $500.00 for any patient. Returned checks and balances older than **60 days** will be subjected to collection fees and finance charges at the rate of **1.5% per month (18% annually).** If you are in need of an extended finance option, we also work with Care Credit, who offers a six month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of the patient services staff for an application.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **$50/hour cancellation fee** (emergencies are an exception). After a broken appointment for treatment, you will be required to prepay your estimated out of pocket in order to reschedule including the failed appointment fee.

After Hours/Weekend Emergencies: In the event of an emergency after regular business hours a **$125 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$250 after hours emergency fee**.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print Name: _____ Date: _____

Sign: _____

PHOTOGRAPHIC RELEASE

1) I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for advertising (including website and social media publication, printed marketing, magazines, television), and lectures, demonstrations, professional publications (dental magazines and journals).

2) I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will not be used unless stated differently below. I agree that my participation is voluntary and I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature:_____

Date:_____

___I do NOT consent

Signature:

Date:

TRISCHA CLARKE DDS
Divine Dental Works
427 West Stone Wood Drive
Broken Arrow, Oklahoma 74012
918-615-3580

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Divine Dental Works' Notice of Privacy Practices.

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

Expiration --3 Years from Initial Signature; Insurance Change; Pt reaches age of 18

I consent for the office of Dr. Trischa Clarke to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ /_____ / _____

_____ /_____ / _____

Signature: _____

☐ Patient ☐ Parent ☐ Guardian / Other

NOTICE OF PRIVACY PRACTICES

Divine Dental Works
Dr. Clarke D.D.S
Dr. Helmerich D.D.S
Dr. Culbertson D.D.S
2307 N. Elm Place
Broken Arrow, OK 74012
Phone: 918-615-3580
Fax: 918-615-3581

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons,we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or

orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance.

If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Divine Dental Works Notice of Privacy Practices.

Patient name_____, Responsible Party: _____
Signature _____