



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



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.

# 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:**

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

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 to third party payors 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 \_\_\_\_\_ DATE \_\_\_\_\_  
                    FIRST                    MI                    LAST                    STATE/  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PROV. \_\_\_\_\_ ZIP/  
E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ P.C. \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED  
IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE/  
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ PROV. \_\_\_\_\_ ZIP/  
BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PROV. \_\_\_\_\_ 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 07-05197/27000

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

REGISTRATION



## 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 – **Radiis Network only**
4. Health Choice – **aka STATE Insurance**
5. Oklahoma Health Care Authority – Sooner Care **Children only**
6. Metlife dental

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