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Passionate About Smiles

Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstances of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you had any signs or symptoms associated with COVID-19 virus.

	YES	NO
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been treated for COVID-19 and are waiting for results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus, or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information risks in cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document I acknowledge that the answers I have provided above are true and accurate.

_____ _____ _____

Signature of Patient ***Witness*** ***Date***

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT
NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for patients and staff to advance the safety of our local community. This document provides the information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and Highly contagious Disease. The world health organization has classified it as a pandemic. You can contract COVID-19 from a variety of sourcesDiseaseDisease.. our practice wants to ensure you are aware of the additional risk of contracting COVID-19 associated with Dental Care.

The COVID-19 virus has a long incubation period. You or your health care providers may have a virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complications due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and The characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease spreads. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to tender care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant To statements from the center for disease control (CDC), and the American Dental Association (ADA), nonessential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are “potentially life-threatening and require immediate treatment to stop ongoing tissue breeding [or to] alleviate severe pain or infection.” The ADA Also recommends that urgent dental care which “focuses on the management of conditions that require immediate attention to receive severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the notice and understand and accept that there is an increased risk of contracting the COVID-19 virus In the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that means the emergency or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____ _____

Signature of patient ***Witness*** ***Date***

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COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT CONSENT FORM

I, _____, knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic. I understand the COVD-19 virus has a long incubation period during which the carrier of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not give the current limits in virus testing. Dental procedures create water spray; this is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

1. I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ (*Initial*)
2. I have been made aware of the CDC, ODA, and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. _____(*Initial*)
3. I confirm I am seeking treatment for a condition that meets these criteria. _____(*Initial*)
4. I confirm that I am NOT presenting any of the following symptoms of COVID-19 listed below:
    a. Fever
    b. Shortness of breath
    c. Dry cough
    d. Runny nose
    e. Sore throat

    _____(*Initial*)
5. I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus and that the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry and dental procedures. _____(*Initial*)
6. I verify that I have not traveled outside of the United States in the past 14 days to countries affected by COVID-19. _____(*Initial*)
7. I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the last 14 days. _____(*Initial*)

_____ _____

Signature ***Date***

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Patient Information:
Please circle and answer those that apply.
(Circle One) Mr. Mrs. Ms. Dr. First Name_____M.I.____Last Name_____
Sex: M F Brith Date_____ Age_____ S.S.. # _____E-mail_____
Street _____ Apt_____ City_____State_____Zip_____
Home Tel.(_____)_____ Cell. (_____)_____ Have you ever been a patient of our practice? Yes No
Referred By_____ Has a family member ever been a patient of our practice? Yes No (Circle one)
Dentist_____Orthordontist_____ Medical Dr. _____
Driver's Lic. # _____
Nearest relative not living with you _____ Tel.(_____)_____
Employer_____ Bus. Tel. (_____)_____ Personal Payment Type: Cash Check Credit (Circle)
In case of an emergency, please contact_____Tel.(_____)_____ Relation_____

Who will be responsible for your account:
(Circle One) Self (If self, skip this section) Spouse Father Mother Other _____
Name_____S.S. #_____
Tel.(_____)_____ Cell. Tel.(_____)_____ E-mail_____
Street _____ Apt_____ City_____State_____Zip_____
Driver's Lic. # _____Employer_____Bus. Tel. (_____)_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquines set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / or her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____ _____ _____
Signature *Date* *Reviewed by* *Date*

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special developments. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and / or medical insurance we will be glad to give you the proper document so that you may submit it to your insurance for possible reimbursements once your procedure(s) are completed. However we are a cash based practice, therefore we are not in the network with any insurance provider, thus all costs must be paid in full upfront.

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute form of payment. Some companies reimburse fixed allowances for certain procedures and others reimburse a percentage of the change. It is your responsibility to pay all costs prior to any treatment or surgery being performed. It is also your responsibility to submit any claims to your insurance company that you would like to try and get reimbursement for. We do have financing options available which you will be responsible for all collection costs, attorney fees, and court costs

This signature on file is my authorization for the release of the information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

_____ _____
Signature *Date*

Authorization

I authorize my surgeon and his / or her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and or mobile phone concerning my appointments.

_____ _____ _____
Signature *Doctor* *Date*

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Name: _____ Age:_____

Chief Complaint:_____

Health History:
To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be asking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.
Reasons for today's office visit?

1. Height_____ Weight_____ Are you in good health? ☐ Yes ☐ No
2. Have there been any changes in your general health in the past year? ☐ Yes ☐ No
3. Are you under the care of a physician? ☐ Yes ☐ No …….. Date of last visit_____
   If so, for what are you being treated?_____
4. Have you unhealed/ recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ☐ Yes ☐ No
   If so, describe where _____
5. Have you had any illness, operation or been hospitalized in the past years? ☐ Yes ☐ No
   If so, describe_____
6. Do you have a prosthetic joint / implant? ☐ Yes ☐ No_____
7. Have you had a heart valve replacement or vascular graft? ☐ Yes ☐ No_____
8. Have you ever had a general anesthesia? ☐ Yes ☐ No_____
9. Have you, or a family member, had any unusual or serious reactions to general anesthesia? ☐ Yes ☐ No
10. Had a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ Yes ☐ No

Eye disease/glaucoma? …… ☐ Yes ☐ No
Mental health problems / anxiety / depression? …… ☐ Yes ☐ No
A removable dental appliance? …… ☐ Yes ☐ No
Pain or clicking of jaws when eating? …… ☐ Yes ☐ No

If you are having surgery today, have you had anything to eat or drink in the last 6 hours? ☐ Yes ☐ No
Who is driving you home?_____

Is there a condition concerning your health that the doctor should be told about? ☐ Yes ☐ No - If yes, please describe:
_____

Do you wish to speak to Dr. Brooks privately about anything? ☐ Yes ☐ No
Is there any family history of:

☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problems

_____

Is this visit related to an accident? ☐ Yes ☐ No If yes, what type of accident? ☐ Automobile ☐ Work related ☐

☐Other:_____
Date of Injury_____ Insurance company handling the claim_____
Claim number_____ Name of Attorney / adjustor _____
Tel #_____

Next <u>4 questions</u> are for Women Only:

	YES	NO		YES	NO
1. Is there a possibility of pregnancy?.....	☐	☐	2. Are you nursing?.....	☐	☐
3. Expected delivery date?_____			4. Are you taking birth control pills?.....	☐	☐

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11317 S. Western Ave. Suite 100B Oklahoma City, OK 73170 | 405.691.0100 | www.myrestoredsmiles.com

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HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES	HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
Rheumatic fever?				Fainting spells?			
Damaged heart valves / mitral valve prolapse?				Convulsions/epilepsy?			
Heart murmur?				Stroke?			
High blood pressure?				Thyroid trouble?			
Low blood pressure?				Diabetes?			
Chest pains/angina?				Low blood pressure?			
Heart attacks?				Kidney troubles?			
Irregular heartbeat?				High cholesterol?			
Cardiac pacemakers?				Are you on dialysis?			
Heart surgery?				Swollen ankles/arthritis/joint disease?			
Pneumonia, bronchitis, chronic cough?				Osteoporosis /osteopenia?			
Asthma?				Osteonecrosis?			
Hay fever/sinus problems?				Stomach / acid reflux?			
Snoring?				Contagious diseases?			
Sleep apnea / CPAP?				Sexually transmitted diseases?			
Difficult breathing / other lung trouble?				Problems with the immune system? Possibly from medication/surgery, etc.			
Tuberculosis?				Delay in healing?			
Emphysema?				A tumor or growth?			
Do you smoke? If so, number of packs a day____				Cancer / radiation / chemotherapy?			
Do you use chewing tobacco				Chronic fatigue/night sweats?			

Blood transfusion?				Are you on diet?			
Blood disorders such as anemia?				A history of alcohol abuse?			
Bruise easily?				A history of drug abuse?			
Bleeding tendency / abnormal bleed?				Contact lenses?			

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Perry L. Brooks, DDS

PATIENT HIPPA / PRIVACY FORM

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patient right section describing your rights under the law. you have the right to review your notice before signing this concept. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that. We restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the health insurance portability and accountability act of 1996 (HIPAA).

The patient understands that:

- Protected healthcare information may be disclosed or used for treatment, payment or healthcare operations.
- The practice has a notice of privacy practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to charge the notice of privacy policies.
- The patient has a right to restrict the users of their information for the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice is my condition treatment upon the execution of this consent. The Patient consents to receiving communication from the practice via email and may revoke this consent in writing at any time.

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION

I give permission for Dr. Brooks & staff to provide information to the parties listed below concerning my healthcare. This information may include lab results, medications being taken, appointment times, change in appointments, doctor's reports, and any other information that this office has about me.

NAME _____ **RELATIONSHIP**_____

NAME _____ **RELATIONSHIP**_____

_____
Date

_____
Print Patient's Name

_____
Signature of Patient or Legal Guardian

_____
Staff Witness

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OFFICE POLICY REGARDING INSURANCE

Our office is pleased to be working with you. We do not accept any form of insurance for payment. However, we will provide proper documents so that you may be able to submit a reimbursement form on your own to your insurance company if you wish to do so.

Our office policy is as follows:

1. Since by agreeing to our office policy we have to wait before we can proceed with the procedure for payment.

2. All payments must be made up front. Anyone wishing to use their insurance will have to file the insurance claim independently once all procedures have been performed. If you wish to file with your insurance please notify the staff so they can give you proper documentation. Please note that the office will not be responsible for filing your insurance claim. This is something you will have to do on your own for reimbursement once all your procedures have been performed.

3. Our office does NOT guarantee that your insurance company will pay. We will give you necessary documentation after all procedures are completed so you may file a claim for reimbursements regarding any of the services that you receive.

4. Our office will provide all the fees upfront. The fees are tailored to your specific needs and procedure(s).

5. Our office will NOT enter into dispute with your insurance company over your claim. This is your obligation and responsibility.

By signing I, _____ understand and agree to comply with all of the above.

_____ _____ _____

Patient's Name Signature Date

_____

Staff Witness

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Medicare Private Contract Opt-Out Form

Age 65 and up only

By signing this contract, I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare or its agent for service provided by Dr. Brooks, even if such service would otherwise be covered.

I agree to be fully responsible for payment of services rendered by Dr. Brooks. I understand that no claims will be submitted to Medicare and no Medicare reimbursements will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the surgeon for services provided.

I understand that Medigap plans do not and other oral health and medical care insurance plans my elect not to, make payments for such services.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would be made, that I am compelled to enter into a private contract that applies to covered care furnished by other health professionals who have opted up.

I understand that Dr. Brooks is excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on 5-18-2020, and it will expire indefinitely.

_____	_____	_____
Patient's Name	Signature	Date

_____
Doctor's Signature

OFFICE GUIDELINES

Immediate Smiles is committed to providing all patients with exceptional service and quality care. Please review our office guidelines and sign/date below. Thank you.

Cancellation Guideline

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment, we require a **24 hour notice**. You may leave a message at any time, within 24 hours, by calling (405) 691-0100. There will be a $25 fee assessed for every half hour missed without 24 hour notification.

We understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations; in such situations we waive the first offense. We record all appointments, cancellation and no show appointments and discourage repeat abuse of our scheduling guidelines.

Financial Obligation/Payment Guidelines

Immediate Smiles is a specialize dental restoration organization which does not accept insurance. Immediate Smiles provides a "Free Educational Consultations", which includes a CT Scan. This educational consultation is designed inform each patients as to (1) if they are a single implant or full-arch restoration candidate and (2) explain the cost and fees associated with the various treatments offered. After the consultation, patients can elect to move forward with treatment. Treatment begins with a first appointment where they will meet with the doctor, have a full oral exam conducted and treatment workup finalized. A payment of 50% of the treatment cost will be required during this first appointment.

Immediate Smiles retains custodian of all CBCT Scanned images and will release all records at the patient's request for a one time transfer fee of $595.00. **Initial _____**

Payment Plan Options

Immediate Smiles offers payment plan options through Proceed Finance and Care Credit. Proceed offers various payment options which can be determine in the office. Care Credit offers interest free payment options along with extended payment plans. Log on to www.carecredit.com for more information. Brochures available upon request.

If you have any questions, please do not hesitate to ask. Thank you for your cooperation and understanding as we institute these policies. These policies will enable us to better serve the needs of all patients.

I have read and understand the above policies.

_____ _____

(Signature of patient or guardian) *(Today's Date)*

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Photo/ Video Release Form

I, _____ (please print), grant permission to Immediate Smiles and its agents and employees the unrestricted right to reproduce the photographs and/ or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising or trade, in any manner or in any medium. I hereby release Immediate Smiles and its legal representatives for all claims and liability relating to images or videos used for the purposes stated. Furthermore, I grant permission to use my statements that were given during interviews or guest lectures, with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

_____	_____	_____
Patient's Name	Signature	Date