PRAIRIE VISTA DENTAL

Dr. Bret Holman • 209 W Central Ave. • Ulysses, KS 67880 • 620-424-4311 • PrairieVistaDental.com

WELCOME

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date:_____ How did you hear about us?_____

Name (First, Middle, Last): _____

I prefer to be addressed as:_____

Gender: ☐Male ☐Female SS#:_____

Birthdate:_____ Age:_____

Address:_____

City:_____ State:_____ Zip:_____

Email Address: _____

Home Phone:_____ Cell Phone:_____

Work Phone: _____

Employer:_____ Occupation:_____

Employer's Address: _____

City:_____ State:_____ Zip:_____

Marital Status: ☐ Single ☐ Married ☐ Partnered
☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name:_____

Spouse's Birthdate:_____ SS#:_____

Spouse's Employer:_____ Occupation:_____

Where and when are the best times to reach you? _____

_____

Other Family Members Seen by Us:_____

_____

_____

EMERGENCY CONTACT (Specify someone who does not live in your household)

Name:_____ Relationship:_____

Phone:_____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself): _____

_____

Do you have dental insurance coverage? ☐Yes ☐No

Dental Insurance Co. Name: _____

Dental Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Dental Insurance Co. Phone: _____

Group #_____ (Plan, Local, or Policy #): _____

Insured's Name: _____ Relationship:_____

Insured's Birthdate: _____ SS#: _____

Insured's Home Phone: _____ Alt. Phone: _____

Insured's Employer: _____ Occupation: _____

ACKNOWLEDGMENTS AND SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature: _____

Date: _____

PRAIRIE VISTA DENTAL

Dr. Bret Holman • 209 W Central Ave. • Ulysses, KS 67880 • 620-424-4311 • PrairieVistaDental.com

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

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, please explain: _____

Name of physician: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing oral or IV bisphosphonates? ☐ Yes ☐ No If yes, please explain: _____

Are you presently taking any medications, pills or drugs? ☐ Yes ☐ No List all medications: _____

Pharmacy name: _____ Pharmacy phone number: _____

Women: Are you pregnant or trying to become 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 ☐ Iodine ☐ Barbiturates (sleeping pills) ☐ Sulfa Drugs ☐ Other

If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

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: _____ Date: _____

Print Name: _____

PRAIRIE VISTA DENTAL

Dr. Bret Holman • 209 W Central Ave. • Ulysses, KS 67880 • 620-424-4311 • PrairieVistaDental.com

DENTAL HISTORY

Why have you come to our office today?_____ Are you in pain? ☐ Yes ☐ No If yes, for how long?_____

Previous Dentist: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you have, or have you ever had any of the following conditions, ailments or treatments?

Bad Breath	☐ Yes ☐ No	Food Collection Between Teeth	☐ Yes ☐ No	Orthodontic Treatment	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	Foreign Objects in Mouth	☐ Yes ☐ No	Pain Around Ear	☐ Yes ☐ No
Blisters on Lips or in Mouth	☐ Yes ☐ No	Grinding Teeth	☐ Yes ☐ No	Pain When Brushing	☐ Yes ☐ No
Broken Fillings	☐ Yes ☐ No	Gums Swollen or Tender	☐ Yes ☐ No	Periodontal Treatment	☐ Yes ☐ No
Burning Sensation on Tongue	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Sensitivity to Cold	☐ Yes ☐ No
Chew on Only One Side	☐ Yes ☐ No	Jaw Fatigue	☐ Yes ☐ No	Sensitivity to Heat	☐ Yes ☐ No
Clenching of Teeth	☐ Yes ☐ No	Lip or Cheek Biting	☐ Yes ☐ No	Sensitivity to Sweets	☐ Yes ☐ No
Clicking or Popping of Jaw	☐ Yes ☐ No	Loose Teeth	☐ Yes ☐ No	Sensitivity When Chewing	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No	Mouth Breathing	☐ Yes ☐ No	Sores or Growths in Mouth	☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you ever experience pain in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

How would you classify your current dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

On a scale of 1-10, how would you rate your smile (10 being the best)? _____

Would you like whiter teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? ☐ Yes ☐ No On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? _____

On average, how many times a day do you brush? _____ How many times a week do you floss? _____

What type of bristles does your toothbrush have? ☐ Soft ☐ Medium ☐ Hard

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: _____ Date: _____

Print Name: _____

PRAIRIE VISTA DENTAL

Dr. Bret Holman • 209 W Central Ave. • Ulysses, KS 67880 • 620-424-4311 • PrairieVistaDental.com

AUTHORIZATION AND RELEASE

Thank you for choosing Prairie Vista Dental for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment but should be considered when making treatment decisions.

Benefits of dental treatment include:

- Relief of pain.
- The ability to chew properly and enjoy eating.
- The confidence and social interaction that a pleasing smile can bring.

Common risks associated with virtually any dental procedure include:

- Allergic reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
- Long-term numbness (parasthesia).
- Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances, permanent numbness.
- Muscle or joint tenderness: Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- Sensitivity in teeth or gums, infection or bleeding.
- Swallowing or inhaling small objects.

We follow procedural guidelines that most often lead to clinical success, but as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you for yourself and for your dependent(s).

My signature below indicates that I have read and understand the general risks associated with dental treatment.

Signature of patient or parent/guardian, if minor _____ Date _____

AUTHORIZATION AND RELEASE AND PAYMENT OPTIONS

I authorize Dr. Holman and Prairie Vista Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to the third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Dr. Holman and Prairie Vista Dental insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment

I understand that I may be charged a finance charge of 1.5% per month (18% annually) if my balance goes beyond 60 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Patient's Signature _____ Date _____

Witness Signature _____ Date _____

PRAIRIE VISTA DENTAL

Dr. Bret Holman • 209 W Central Ave. • Ulysses, KS 67880 • 620-424-4311 • PrairieVistaDental.com

PAYMENT, CANCELLATION AND INSURANCE POLICY

PAYMENT POLICY

Payment for services is expected at the time service is provided.

CANCELLATION POLICY

Please give us 24 hours' notice if you are unable to make your scheduled appointment. A minimum $40.00 cancellation fee will be applied if less that 24 hours' notice is given. If you are scheduled for a longer appointment, with either the dentist or hygienist, you may be charged a cancellation fee of $1.00 per minute scheduled if less than 24 hours' notice is given. If you cannot make the appointment because you are sick, the cancellation fee may not be charged if you call as soon as you know you are unable to make the appointment and depending on the circumstances.

IF YOU HAVE DENTAL INSURANCE

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will ESTIMATE your deductible and the portion not covered by your Insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have any questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

I understand that I will be required to pay my estimated portion of Dr. Holman's fees at the time of treatment unless prior arrangements have been made.

I also understand that I am ultimately responsible for any and all services rendered, regardless of insurance reimbursement.

I have read and agree to the statements listed above.

Name: _____ Relationship to patient: _____

Signature: _____

Date: _____

PRAIRIE VISTA DENTAL

Dr. Bret Holman • 209 W Central Ave. • Ulysses, KS 67880 • 620-424-4311 • PrairieVistaDental.com

PRIVACY NOTICE

I understand that under the Health Insurance Portability and 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 be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy 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 Privacy 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 that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

PRAIRIE VISTA DENTAL

Dr. Bret Holman • 209 W Central Ave. • Ulysses, KS 67880 • 620-424-4311 • PrairieVistaDental.com

HELPFUL INFORMATION

MORE ABOUT YOUR FIRST VISIT WITH US

At your first visit with us, we will begin the process of learning about your current dental needs, desires, and concerns. Plan on spending about 1.5 to 2 hours with us.

We will work together in a fashion that allows you to participate and give us input. Our primary goal for this appointment is to help you learn enough about your needs and options that you will be able to make educated decisions based on what you feel is best and most appropriate for you both currently and long-term.

We will achieve this by:

- Completing a careful evaluation process so you will be fully informed of your current status.
- Discussing all appropriate treatment options, including pros and cons of each approach with you.
- Helping you to prioritize what you would like to accomplish with us.
- Working to develop a plan of action based around what is most important to you, what works best with
- Assisting you with filing insurance claims when necessary.

Our fee for the new patient visit is typically $275. The new patient visit includes assessing your immediate and long-term concerns, a tooth and dental restoration evaluation, a soft tissue examination, an oral cancer screening, a periodontal examination and charting, a TMJ screening, a photographic survey, and a complete series of X-rays and diagnostic records as needed. This fee also covers a follow-up visit to go over findings from your initial visit, if needed. We ask that you be prepared to pay this fee at the time of service. For your convenience, we accept personal checks and Visa, MasterCard, Discover and American Express credit cards.

OUR ASSURANCE TO YOU

We understand that the way we begin to work with our patients may be different than the way you have worked with previous dentists. Virtually all new patients to our practice tell us that their initial appointment was the most useful time they have ever spent with a dentist! Thus, we are fairly confident that you will likely feel this way, as well.

If at any time during your visit you feel that we are not the right dental practice for you, we will not charge a fee for this first visit.

Please feel free to call us if you have any questions about your first visit with our practice. We look forward to seeing you soon!