Welcome to Advantage Dental in Bixby, Oklahoma. Our services include everything from examinations and cleanings, to fillings, extractions, crowns, bridges, dentures, and implant dentistry. We strive to give you the ultimate results to enhance the quality of your life.

Thank you for choosing to trust us with your health! We want to extend our personal greetings and a very warm welcome to our dental practice. Dr Knapp and the team at Advantage Dental are committed to doing everything possible to provide you with excellent dental care and also to make your visit to our office as pleasant and as comfortable as possible.

The following information will be very useful to you:

- At the time of your first appointment we will listen closely to your concerns and conduct a thorough examination. Please complete and bring the enclosed packet with you. Before any treatment begins we will sit down with you and advise you of your options so you can make an informed choice regarding the best treatment for your specific needs.
- Some patients find it helpful to make a list of questions they want discussed during your initial visit. Please plan at least 90 minutes for your New Patient Experience to allow us to address all your concerns.
- It is important to note that we provide patients with both the surgical and restorative phases of dental implant treatment in our office. Completing all facets of implant treatment in one office by one doctor is a great benefit to patients. Dental implants are the most advanced and natural-looking tooth replacement system ever devised. Implants provide stable, fixed restorations and enhance the quality of patients' lives. Dental implants never decay or require root canals and they help preserve the jawbone, which can prevent the appearance of premature aging.
- We have a registered dental hygienist in our office that will clean your teeth professionally and provide you with home care instruction.
- Our practice is truly a family practice that is based on word-of-mouth referrals. Our patients have helped our practice grow by referring friends and family to us knowing they are in good hands and we will provide gentle, compassionate care to their loved ones. We hope you will be pleased with your care and will refer your friends and family also! If we don't meet 100% of your expectations please let us know how to serve you better.
- We request 48 hours cancellation notice if you are unable to keep your appointment. We do our best to reserve Dr. Knapp's time for you and to stay on schedule knowing your time is valuable.
- Our office is located at 119th St and Memorial Drive in Bixby, OK. We are on the east side of Memorial Drive on the north end of the building. Watch for the Warren Clinic (which faces Memorial Dr) in the Town and Country Shopping Center. Please feel free to call us at 918-394-0303 if you have any questions or concerns.

We look forward to meeting you on_____ at _____. Have a wonderful day.

Your Team at Advantage Dental

General Patient Information

Patient Name_____ Nickname_____ DOB_____SSN_____

Circle your answer: Male Female Marital Status: Single Married Divorced Widowed

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Cell Phone ( )_____ Work ( )_____

Employed By:_____ Student at:_____ Email:_____

Would you like to receive emails Y N or text messages to your cell phone Y N as reminders for your appointments?

How did you hear about us? Please circle all that apply. Phone Book 1800dentist Billboard Dentist Name_____

Family/Friend Name _____ Website Search Name _____

Dental Insurance Information Are you covered by a dental insurance plan? _____ Y _____N

Policy Holder Name_____ DOB _____ SSN_____

Policyholder ID# _____ Employer Name/Group_____

Insurance Co Name, Address and Phone #_____

Please answer the following questions so we may treat your dental health correctly. (Circle your answers)

I visit the dentist: Annual Semi-Annual Only when I have a problem Date of Last Visit_____

I brush my teeth: After meals Once a day At Bedtime In the morning When I remember Not regularly

I use dental floss: After meals Once a day At Bedtime In the morning When I remember Never

Are you nervous about dental treatment? Y N Do you gag easily? Y N Do you grind or clench your teeth? Y N

Do you have frequent headaches? Y N On a scale of 1-10 (10 is excellent) how would you rate your smile? _____

Patient Authorization

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental office any benefits that are otherwise payable to me. I understand that my dental insurance may pay less than the estimate or may not cover certain treatments.

I certify the above information is accurate and complete and that in consideration of treatment and services rendered and services rendered to me or my dependents by this dental office, I accept responsibility and agree to pay for services rendered and/or any balance due

_____ _____

Signature of Patient, Parent or Legal Guardian Date

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: _____
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 taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ 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, please explain: _____

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 Problem ◯ 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 _____

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 _____

ADVANTAGE DENTAL

FINANCIAL INFORMATION

Patient Name_____

Payments for services are due at the time services are rendered, unless prior payment arrangements have been made and approved in writing. Your estimated portion of the fees will be computed at the time your treatment plan is prepared. This amount is due for services scheduled the day of your appointment. We accept Visa, MasterCard, Discover, checks and cash. For larger amounts we offer Care Credit and Chase Health Advance financing for those who qualify. We will be happy to assist you to complete this process. Any balance owed after the insurance company pays will be due and payable within 30 days. Returned checks and balances older than 60 days are subject to additional collection fees and interest charges of 1.5% per month. If an account becomes delinquent, the responsible party will be liable for all legal fees incurred during the collection of the account. **Returned check fee is $35 per occurrence.**

Effective immediately there will be a $25 per 30 minute fee for failing to keep your appointment without 48 hours notice. In order to provide you with the highest standard of care we reserve Dr. Knapp's time for each patient in advance. While we make every effort to fill cancelled or failed appointments; it is not always possible with short notice or no notice at all.

Your insurance policy is a contract between you, your employer and the insurance company and we are not a party to that contract. We make every effort to estimate the benefits provided under your plan based on the information we receive but it is impossible to be exact. Your insurance company may not provide us with complete or accurate information when we verifiy benefits and will not guarantee payment in advance of claims being submitted. Not all services are covered benefits in all plans. Some policies limit or restrict payment of some procedures to keep the premiums lower for the employer/employee. Some plans will reduce benefits to the "lowest standard of care", such as paying for a amalgam (silver) filling rather than a resin (tooth-color) filling or downgrading a porcelain crown to a metal crown. They are careful to point out this does not change the recommended treatment plan of the doctor; rather it is a limitation of the payment allowed for that type of procedure.

We are here to help you; if you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask.

I give my permission for Dr. Jason Knapp and his team to take necessary diagnostic films, photos or study models to properly enable complete diagnosis and treatment. I understand my treatment plan will be adjusted as necessary if diagnosis changes occur and will be discussed with me prior to treatment.

I assign dental benefit payments (if applicable) to be paid directly to Advantage Dental from any insurance company or benefit plan under which I may be covered.

I understand that my insurance policy is an agreement between my insurance company and me. I also understand that I am responsible for payment of my account regardless of my insurance benefits and that Advantage Dental files claims to my insurance as a courtesy to me.

I have read the above statements and fully understand agree to these terms and conditions.

_____ _____

Signature of Patient or Responsible Party Date

HIPPA CONSENT FORM

I give Advantage Dental, PC my consent to use or disclose my protected health information to carry out my treatment, to obtain payments for insurance companies and for healthcare operation quality reviews.

I understand I may review Advantage Dental's Notice of Privacy Practices available at the front desk before signing this consent. I understand Advantage Dental may revise their Privacy Practices at any time and I may review a copy of the revised notice at the office.

I understand I have a right to request a restriction of how my protected health information is used. However, I also understand that this may limit Advantage Dental's ability to provide adequate treatment. If Advantage Dental determines that my requests compromise my treatment I may be dismissed as a patient of Advantage Dental.

I understand I may revoke this consent at any time in writing, except for information that has already been used or disclosed.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

I GIVE MY PERMISSION TO HAVE MY MEDICAL/DENTAL CONDITIONS DISCUSSED WITH THE FOLLOWING FAMILY MEMBERS/FRIENDS.

_____ _____

_____ _____

_____ _____

Signature of Patient/Parent/Legal Guardian Date