Welcome To Our Office

Jeffery M. White, D.D.S.
13701 East Mississippi Avenue #300
www.drjeffwhite.com
Aurora, CO. 80012
(303) 344- 2705
Fax: (303) 344- 4125

We would like to take this time to thank you for making an appointment with our office. We have enclosed a "**Patient Information Sheet**" for you to complete at your leisure. Please bring the forms with you on your first visit or you may return them by mail. In order to make your visit with us as smooth as possible, we ask for your help in providing us with a current insurance card that includes:

- Name of subscriber (employee)
- Subscriber date of birth
- Group Number
- Insurance phone number
- Full- Time Student info (if applicable)
- Current X- rays
- ID/ Social Security Number
- Group Name
- Insurance address
- Any benefit information pertaining to your visit
- Referral Slip from referring doctor

We ask that you review your benefits including any exclusions prior to your appointment, or you may contact your carrier for any benefit questions.

Enclosed you will find a "**Notice of Privacy Practices**" brochure.

You will also find an "**appointment card**" to verify your appointment. If there is a conflict in keeping your appointment date and/ or time please let our office know two days in advance. We will make every effort to accommodate your schedule. We offer a courtesy call as a reminder of your appointment and **require** a return call of confirmation **no less than 24 hours** prior to your appointment. If no confirmation call is returned, we will assume you are unable to keep your appointment and therefore will remove your appointment.

Cost for the initial visit/ consultation is **$85** for exam, **$98** for full or panoramic x-ray, or **$25** for a single x- ray. Implant Consult is **$85**. TMJ consult is **$145**. Orthognathic consult is **$145**. You are requested to pay in full for your initial visit. Should your insurance pay for these services, the credit will be applied toward the cost of surgery. If no surgery is needed, a refund will be issued to you.

At our office it is our highest priority to meet the needs of each and every patient. Please let us know what we can do to make your visit a comfortable one.

Thank you again and we look forward to meeting you in person soon!

Dr. Jeffery White and Staff

Jeffery M. White, D.D.S.
Oral and Maxillofacial Surgery
Patient Information Sheet
Please complete All requested information.

Date_____ Soc. Sec. #_____Age _____ Birthdate_____

Name_____Home(____)_____
Address_____Work (____)_____
City_____State_____Zip_____ Cell (_____)_____
E-mail_____

Sex: M___ F___ Minor__ Single__ Married__ Partner__ Divorced__ Widowed__ Separated__

Employer_____Business Phone(___)_____
Business Address_____
Who should we thank for referring you?_____
In case of emergency, who should we contact?_____Phone(___)_____

PRIMARY DENTAL INSURANCE
Person Responsible for account_____
Relationship to patient_____Birthdate_____Soc.Sec.#_____
Address _____Home Phone(___)_____
City_____State_____Zip Code_____
Responsible party employed by_____Business phone(___)_____
Business Address_____Occupation_____
Insurance Company_____ Insurance Phone Number(___)_____
Insurance Address_____
Subscriber ID#_____Group/Policy#_____

SECONDARY DENTAL OR MEDICAL INSURANCE
Insured Name_____
Relationship to patient_____Birthdate_____Soc.Sec.#_____
Address _____Home Phone(___)_____
City_____State_____Zip Code_____
Insured employed by_____Business phone(___)_____
Business Address_____Occupation_____
Insurance Company_____ Insurance Phone Number(___)_____
Insurance Address_____
Subscriber ID#_____Group/Policy#_____

If you have an insurance card please give it to the receptionist to make a copy.

As a courtesy to our patients we will bill your insurance for you if you have provided us with all of the necessary information. **Surgical fees are due at the time of surgery.** All insurance estimates are only estimates. Your final portion is determined by your insurance company. I hereby authorize Jeffery M. White to release part of my medical record on my behalf and assign benefits payable to him directly. I understand that I am responsible for all charges whether or not paid by insurance. For your convenience our office accepts cash, check, VISA, MasterCard, and Discover.

Signature of patient or guardian_____ Date_____

PAYMENT DUE ON DAY OF SERVICES

Patient Medical Information

It is important that we understand your medical and dental history. These facts have a direct bearing on your medical care. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Patient name_____

What is the purpose of your visit today?_____

Circle Yes or No for All of the following :

Rheumatic Fever	Y N	Pneumonia	Y N	Hepatitis	Y N
Heart Trouble	Y N	Tuberculosis	Y N	Kidney Disease	Y N
Heart Attack	Y N	Shortness of Breath	Y N	Diabetes	Y N
Heart Murmur	Y N	Chest Pain	Y N	Thyroid Disease (Goiter)	Y N
Coronary Artery Disease	Y N	Seizures	Y N	Arthritis	Y N
High Blood Pressure	Y N	Epilepsy	Y N	Stomach Ulcers	Y N
Angina	Y N	Fainting	Y N	Glaucoma	Y N
Stroke	Y N	Psychiatric Treatment	Y N	Mouth Sores	Y N
Heart Palpitations	Y N	Dizziness	Y N	Implants Metal/Plastic	Y N
Pacemaker	Y N	Nervous Disorder	Y N	Radiation Therapy	Y N
Heart Surgery	Y N	Bleeding Disorder	Y N	Clicking/Popping Jaw	Y N
Congenital Heart Disease	Y N	Anemia	Y N	Sinus/Nasal Problems	Y N
Lung Disease	Y N	Bleeding Tendency	Y N	Immune Disorder	Y N
Asthma	Y N	Blood Transfusion	Y N	Recurrent Infections	Y N
Emphysema	Y N	Bruise Easily	Y N	Easy Gagging	Y N
Chronic Cough	Y N	Liver Disease	Y N	Steroid Therapy	Y N
Bronchitis	Y N	Jaundice	Y N	Diet Therapy	Y N
Women-Pregnant	Y N	Drug Abuse	Y N	Alcohol Abuse	Y N
How many months_____		Knee/Shoulder/Hip Replacement	Y N	Any Artificial parts	Y N

Are You Allergic to or had a Bad Reaction to:

Local Anesthetic	Y N	Aspirin	Y N	Latex Gloves	Y N
Penicillin	Y N	Ibuprofen	Y N	Codeine	Y N
Amoxicillin	Y N	Barbiturates	Y N	Other Pain Medicine	Y N
Other Antibiotics	Y N	Sedatives	Y N	List_____	

List_____

Any other allergies_____

Type of reaction_____

Current weight_____

List current medications and dose _____

_____

Do you have any other condition, disease, or problem not listed above?_____

_____

Do you smoke or use tobacco products? _____How much?_____

Are you now under the care of a physician?_____ For what condition_____

Name of Physician_____Phone Number_____

Name of Dentist_____Phone number_____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have completed this questionnaire fully and to the best of my ability.

Signature of Patient or Guardian: _____ Date

Reviewed by _____ Date _____

Jeffery M. White, D.D.S.
13701 E. Mississippi Ave., Ste 300
Aurora, Colorado 80012
Oral and Maxillofacial Surgery

Financial Policy

To all our patients:

Thank you for your trust in our office. Our usual and customary fees apply equally and without prejudice to everyone. For your convenience we accept cash, personal check, VISA, MasterCard, and Discover.

You may also finance your services through **Care Credit.** This program offers flexible payment plans, including low or zero (0) interest loans.

To our patients with insurance:

It is the responsibility of the patient to know and understand their insurance coverage. You are responsible for your entire account. When all necessary information is provided to bill an insurance company we will do our best to collect payment for you. We can give you an estimate of your portion based on benefits the insurance company has given us but again this is only **an estimate.** Your final portion will be determined by your insurance company. If no payment is made by your insurance company within 90 days, you are responsible for the entire account bill. Verification of eligibility and benefits is determined once the insurance company receives our claim. If, at that time, the claim is denied, the bill is the total responsibility of the patient.

Without a copy of your card from your current dental carrier we will be unable to be sure of whether or not they will pay on a claim from our office. If it is determined that your insurance carrier will not pay on a claim from our office the bill is due from you in full at that time.

When an insurance company requires a pre-authorization to proceed with treatment, our office will send the paperwork and notify the patient of the results. If surgery is scheduled before this pre-treatment estimate has been approved the patient may elect to pay full price on the day of surgery. If a referral form is required by your insurance company you are responsible for making sure we receive it from the general dentist.

The estimated portion due from you is due on the day of surgery or your appointment will be rescheduled.

To our minor (under 18) patients:
Minor patients will be seen when they are accompanied by their parent or guardian. The parent who accompanies the minor is the one who will be billed in full for the treatment given. We will not bill a missing parent due to divorce or any other complication. Please make arrangements before treatment so this will not be a problem.

Cancellation policy:
A 24-hour cancellation is required to avoid a $35.00 charge.

Service Charge:
If I do not pay the balance due within 25 days of the monthly billing date, a service charge of $5.00 will be added to the account each billing cycle. I promise to pay any legal collection cost and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Returned Check Fee:
A $30.00 charge will be applied to any returned check.

I have read and understand the financial policy. I am responsible for this account whether or not paid for by insurance.

_____ _____
(Signature of patient/guardian) **(Date)**

Jeffery M. White, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our NOTICE OF PRIVACY PRACTICES before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our NOTICE OF PRIVACY PRACTICES. If we change our privacy practices, we will issue a revised NOTICE OF PRIVACY PRACTICES, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our NOTICE OF PRIVACY PRACTICES, including any revisions of our notice, at any time by contacting:

Contact Person: Natasha Peters-Jones /Office Coordinator and/or Jeffery M. White, D.D.S.
Telephone: 303.344.2705 **Fax:** 303.344.4125
E-mail: jwdbusiness@comcast.net
Address: 13701 E. Mississippi Ave., Ste 300 Aurora, CO 80012

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your NOTICE OF PRIVACY PRACTICES. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Jeffery M. White, D.D.S.
13701 E. Mississippi Ave., Ste 300
Aurora, CO 80012
(303) 344-2705 phone (303) 344-4125 fax

Pre-Surgical and Anesthetic Instructions

1 Please **NO FOOD** or fluids, including water, for **SIX** hours before surgery. You may take your necessary daily medications with a sip of water.

2 You MUST have someone come with you to drive you home, preferably a parent or relative. We cannot allow you to take a taxi or bus by yourself.

3 Please wear a **SHORT SLEEVE SHIRT WITH LOOSE FITTING SLEEVES** the day of surgery so your blood pressure can be monitored and anesthesia administered. Do not wear jewelry around your neck. Please remove all fingernail polish for an oxygen sensor.

4 If you wear contact lenses, please do not wear them on the day of the surgery. Also avoid wearing shorts as you may become chilled waking up from anesthesia.

5 Prior to the surgery use the restrooms located down the main corridor as you walk into our office.

6 Suggested food to have on hand at home the day of surgery: creamy soup, applesauce, milk shakes, pudding, apple juice, Jell-O, non-spicy soft foods, yogurt, ice cream, etc.

7 Long acting “novocaine” and medications to help reduce swelling are available. Please advise Dr. White if you desire these to help with pain control and swelling.

8 Our receptionist will call you two days before your surgery to confirm your appointment. Please call our office before then if you have any questions.

9 One method to help reduce pain and swelling from surgery is to take two Ibuprofen tablets (2X200mg) one hour before your appointment with a sip of water. Sometimes this will give you a head start on pain.

10 **REMEMBER TO BE OPTIMISTIC!** It won’t be as bad as you think! And have a good dinner the night before surgery as it may be several days before you diet returns to normal.

Jeffery M. White, D.D.S.
13701 E. Mississippi Ave., Ste 300
Aurora, CO 80012
303-344-2705

CARE OF MOUTH AFTER ORAL SURGERY

1) Please **DO NOT SMOKE** for 3 days! Smoking delays healing and increases your post-surgical problems. Try to avoid smoking and chewing tobacco for as long as possible.

2) Bite firmly on gauze until arriving home. Remove the gauze and drink 1 or 2 cups of creamy soup, yogurt, milk, or a milkshake to **coat your stomach. Then take the pain medication** before the numbness wears off. Women on birth control pills should be aware of alternative birth control methods when taking antibiotics. Moisten another gauze and place it in your mouth for 30 minutes. Replace gauze as needed. Put an old towel or pillowcase on your pillow. Some oozing of blood is normal for 6-8 hours, even overnight. Some patients may ooze for 24-36 hours.

3) **Do not disturb the surgical site for at least 8 hours.** After that time you can gently rinse your mouth with warm salt water. Mix 1/8 tsp. of salt in 8 oz. of warm water and try to rinse 4-5 times daily.

4) Bleeding. Some **oozing of blood is to be expected for 6-8 hours.** Keep your head elevated on one or more pillows to reduce excess oozing. If oozing continues or is excessive place a damp black tea bag over the area and bite on it with firm steady pressure for one hour. Rest and do not exert yourself. If excessive bleeding continues contact the office at the above number.

5) Pain. **Use the stronger pain reliever first** for severe pain. Coat your stomach with food before taking pain relievers to reduce stomach upset and nausea. Small pieces of ice chips can be placed on the surgical area to reduce pain as well. Ice packs on the jaw area for 48 hours after surgery sometimes helps with pain reduction.

6) Nausea. This can result from swallowing blood, pain medications, or from anesthesia. Drink small amounts of 7-Up or Ginger Ale, milk or ice chips to help alleviate nausea. Switch to a milder pain reliever if possible. **If nausea is uncontrolled contact the office.** Anti-nausea medications can be prescribed to counteract the problem.

7) Swelling. **Ice packs should be used on the cheeks immediately after surgery for the first 48 hours.** Use them on 30 min-off 30 min. Warm towels or a compress to the cheeks or surgical site should be used after 48 hours.

8) Nutrition. A liquid diet consisting of soup, juices, pudding, milkshakes, etc. is generally recommended the day of surgery. With time, patients advance to a soft food such as applesauce, cottage cheese, mashed potatoes, scambled eggs, etc. Blenderized food or puree is useful. It may take 5-7 days to return to a normal diet after difficult surgery. Nutritional supplements like Ensure Plus and boost are helpful. **DO NOT USE A STRAW!**

9) In the case of impacted teeth or difficult surgery all of the above effects of surgery will be exaggerated. The skin may discolor and you will have difficulty opening your mouth. This is no cause for alarm. Swelling will reach its peak 2-3 days after surgery and then start to subside. Sometimes bone chips will work themselves out from where a tooth is removed.

Success of post-operative healing now depends on proper care and management. **Should any reactions to medication develop (rash, itching, hives) stop taking your medications and call this office immediately.** Our voice mail system is set up to contact Dr. White after hours. On weekends Dr. white or an on-call oral surgeon will be accessible.

NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy, and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of privacy of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law, to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice, who may need access to your information must abide by this Notice. All subsidiaries, business associates, (E.G. A billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical on formation we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on the posted copy.

NOTICE OF PRIVACY PRACTICES

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.

Effective Date: April 13, 2003

Privacy Officer:

Natasha Peters-Jones

JEFFERY M. WHITE D.D.S.

ORAL & MAXILLOFACIAL SURGERY

13701 E. MISSISSIPPI AVE., SUITE 300

AURORA, COLORADO 80012

(303) 344-2705

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed. **For treatment.** We may use medical information about you to provide you with medical treatment or services. Example: in treating you with a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that treatment and services received from us may be billed and payment may be collected from you, an insurance company, or third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnoses, and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for your health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services, and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can be Made Without your Consent or Authorization

- As required during an investigation by law enforcement agencies.
- To avert a serious threat to public health or safety.
- As required by military command authorities for their medical records.
- To workers' compensation or similar programs for processing of claims.
- In response to a legal proceeding.
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official.
- As required by the US Food and Drug Administration (FDA)
- Other health care providers' treatment activities.
- Other covered entities' and providers' payment activities.
- Other covered entities' healthcare operations activities (to the extent permitted under HIPPAA)
- Uses and disclosures required by law.
- Uses and disclosures in domestic violence or neglect situations.
- Health oversight activities.
- Other Public activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, In writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING

DISCLOSURES AND CHANGES TO YOUR MEDICAL INFORMATION

RIGHT TO REQUEST RESTRICTIONS You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or heath care operations or to someone who is involved in your care or the payment for your care. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your Request, you must tell us what information you want to limit.

RIGHT TO AN ACCOUNTING OF NON-STANDARD DISCLOSURES

You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 3003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect, copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement, and will provide you with a copy of any such rebuttal. Statements of any disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

YOUR INDIVIDUAL RIGHTS REGARDING

YOUR ACCESS TO MEDICAL INFORMATION

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO PAPER COPY OF THIS NOTICE. You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request how we should communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.