Welcome

Eagle Mountain Family Dental, PC

PATIENT INFORMATION

LEGAL NAME_____ **PREFFERED NAME**_____
FIRST LAST MI

ADDRESS_____
STREET APT# CITY STATE ZIP

BIRTH DATE_____ **TELEPHONE** (___) _____ (___) _____ (___) _____
MM/DAY/YR CELL # WORK# HOME#

DRIVERS LICENSE#_____ **SOCIAL SECURITY #**_____ - _____ - _____

EMAIL ADDRESS:_____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME:_____ **Relationship**_____
ADDRESS:_____
CITY/STATE/ZIP:_____
TELEPHONE (___) _____ (___) _____ (___) _____
HOME# WORK# MOBILE/PAGER#

INSURANCE INFORMATION

EMPLOYEE NAME:_____ **EFFECTIVE DATE**_____

EMPLOYEE BIRTH DATE_____ **EMPLOYEE SOCIAL SECURITY OR ID#**_____
MM/DAY/YR

EMPLOYER NAME_____

CARRIER NAME_____ **TELEPHONE #**_____

ADDRESS_____
STREET CITY STATE/ ZIP

GROUP #_____ **SUBSCRIBER #**_____

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that unforeseen complications or new conditions may arise that may result in more extensive treatment possibly at a higher cost. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that having dental insurance is not a guarantee of benefits. I understand I am responsible for any amount my insurance does not cover. I further understand that a 1.25% finance charge (15% APR) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Consent and Acknowledgement of Receipt of Notice of Privacy Policies

I have been offered a copy of Eagle Mountain Family Dental, PC's Notice of Privacy Policies.

PATIENT_____ **DATE**_____ **WITNESS**_____

Parent or Responsible Party_____ Relationship to Patient_____

PLEASE FILL OUT THE BACK PORTION

Appointment and Payment Policy Agreement

Failure to cancel or reschedule appointments appropriately, not only affects the doctor and staff, but also other patients who may have been in need of that time. Please be respectful of your time and ours.

I, The Client/Patient Agree:

To Be On Time:

- To receive the doctor's or hygienist's services, **on time**, for every appointment.
- I understand that reminder call services may be provided as a courtesy. However, I understand this is not a guarantee and should I not receive one, I am still responsible for my appointments and any consequences associated with failing to keep or be on time for appointments.

To Give At Least 24 Hours Notice:

- Phone the office at **(817)444-3890 at least 24 hours in advance** of any appointment I need to miss, cancel or reschedule. Remember that we are closed early on Thursdays so cancellations of Monday appointments must be called into us on Thursday mornings.

- Of the **first** appointment missed, canceled, or rescheduled **without** 24 hours notice there will be a notification letter mailed to your residence.

- If a **second** appointment is missed, canceled, or rescheduled **without** 24 hours notice there will be a **$35 missed appointment fee.**

- If a **third** and/or future appointment is missed, canceled, or rescheduled without 24 hours notice there will be a **35% of the total appointment fee charged to your account, which must be paid before another appointment can be scheduled.**

- If a **fourth** appointment is missed, canceled, or rescheduled without 24 hours notice. **It is the policy of Eagle Mountain Family Dental, PC to discontinue dental services to patients and/or families who fail to keep scheduled appointments four(4) times.**

Each "canceled, late canceled, or failed" appointment will be marked in the patient's chart. If a fourth "Failed appointment or Late canceled" appointment, you will be sent a letter of termination allowing you 30 days to have the patient's records transferred to another dentist of your choice. The clinic will be available for <u>emergency</u> dental services only during that 30-day period. If you have any further questions regarding this policy, please feel free to discuss your concerns with us.

Patients who arrive more than 15 minutes late to their scheduled appointment time may be asked to reschedule as a courtesy to our other scheduled patients or they may have to wait to accommodate the schedule.

Payment for services is due at the time services are rendered. We accept cash, checks, Master Card, Visa, American Express, Discover and Care Credit.

Assignment of Insurance: Our office understands the value of insurance benefits to our patients and we gladly accept assignment of insurance benefits. Rarely does an insurance company cover an entire bill. We will do our best to estimate your deductible and the portion that will be covered by your insurance carrier. However, any balance remaining is your direct responsibility. This includes any non-covered services, yearly deductible, or co-payments particular to your individual insurance plan. Since it would be impossible for us to be familiar with the details of every insurance plan, we ask that you be aware of your financial responsibilities under the terms of your policy.

I certify that I am covered by _____Insurance Co. and I assign directly to Eagle Mountain Family Dental, PC all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize Eagle Mountain Family Dental, PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Appointment Policy and Payment Policy Agreement
I have read and understood the above agreement completely and agree to comply fully with collections of any fee that I owe.

_____ _____
Signature Date

Name _____Date _____

Date of last health care exam: _____What was this exam for?_____

Physician's Name_____Telephone #_____

Preferred Pharmacy_____ Telephone #_____

Have you been hospitalized in the last 5 years? (Please circle)…. No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Heart Stent? Date?	No	Yes
Anxiety / Depression / Nervousness	No	Yes	Stroke Date?	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Hemophilia	No	Yes
Asthma	No	Yes	Hepatitis, Any Form	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Joint Replacement? Date?	No	Yes
Blood Transfusion	No	Yes	Kidney Disease	No	Yes
Cancer or Tumor?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cosmetic Surgery	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Cortisone Medicine	No	Yes	Pain in Jaw Joints	No	Yes
Diabetes	No	Yes	Psychiatric Treatment	No	Yes
Drug Addiction: Current or Past	No	Yes	Previous Biopsies	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Epilepsy	No	Yes	Rheumatic Fever	No	Yes
Fainting or Dizzy Spells	No	Yes	Scarlet Fever	No	Yes
Glaucoma	No	Yes	Sinus , Allergies, Hay Fever or Hives	No	Yes
High Blood Pressure	No	Yes	Slow-Healing Mouth Sores	No	Yes
Heart Murmur	No	Yes	Thyroid Disease	No	Yes
Heart Failure Date?	No	Yes	Tuberculosis (TB)	No	Yes
Angina Pectoris (Chest Pain)	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Ulcers	No	Yes
Heart Valve (artificial) or Heart Transplant Date?	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease Date?	No	Yes	Recurrent Illnesses	No	Yes
Heart Attack Date?	No	Yes	Do you snore?	No	Yes
Heart Surgery Date?	No	Yes	Treatment for Sleep Apnea	No	Yes

Are you taking any of these medications?

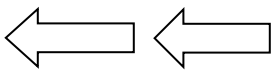
Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any over-the-counter, dietary or herbal supplements you are taking:

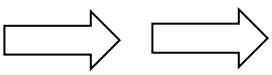
_____ _____ _____

_____ _____ _____

_____ _____ _____



PLEASE FILL OUT THE BACK PORTION



Do you require an antibiotic premed before your dental procedure? ……..NO……YES

If "YES" what do you take?_____

Please list any medications you are currently taking:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Women: Are you pregnant? ……..No Yes
Are you a nursing mother?.....No Yes
Are you taking birth control pill?....No Yes

Do you use tobacco? If yes, circle type: **smoke chew**
How much per day? _____For how long?_____
Do you consume alcohol? _____
If yes, approximately how many alcoholic beverages per week?_____
Do you use any mood altering drugs other than those previously listed?

Abnormal Blood Pressure? (Please circle)
Have you ever received a diagnosis of "high blood pressure"?.....No Yes

Are you allergic or have you had a reaction to:_____

Penicillin or other antibiotics …….No	Yes	(please specify)	
Codeine, Valium or other sedatives....No	Yes	(please specify)	
Aspirin, Ibuprofen or Tylenol …..…..No	Yes	Latex or Metals…….. No	Yes
Local anesthetics ……No	Yes	Other (please specify)	

ORAL HEALTH

How often do you visit the Dentist? ____Every six months ____Once a year ____ Whenever I'm in pain!
Are you having any discomfort at this time? ____ Yes _____ No

Visit History	**When is the last time you had a dental cleaning?** **____6 months ago ____1-2 years ago ___Over 2 years ago___Never**			
Sensitivity	Are your teeth sensitive to:			
	Sweets?	Yes	No	Sometimes
	Hot?	Yes	No	Sometimes
	Cold?	Yes	No	Sometimes
	Pressure?	Yes	No	Sometimes
Dry Mouth	Does your mouth feel dry?	Yes	No	Sometimes
	Do you feel thirsty all the time?	Yes	No	Sometimes
Gums	Do your gums bleed when you brush?	Yes	No	Sometimes
	Do they bleed when you floss?	Yes	No	Sometimes
	Do your teeth wiggle- even slightly?	Yes	No	Sometimes
	Have you ever had gum surgery?	Yes	No	Sometimes
	Have you ever had, or have you ever been recommended a "deep cleaning"?	Yes	No	Sometimes
Grinding/ Jaws	Do you have pain in your jaw joints (TMJ)?	Yes	No	Sometimes
	Does your jaw joint pop or click?	Yes	No	Sometimes
	Do you have difficulty chewing?	Yes	No	Sometimes
	Do you clench your teeth?	Yes	No	Sometimes
	Do you grind your teeth? If yes, do you wear a nightguard? □ Yes □ No	Yes	No	Sometimes

_____

Significant findings from questionnaire or oral interview /Dental management considerations:

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient Signature ***Doctor Signature*** ***Date***

EAGLE MOUNTAIN FAMILY DENTAL, PC
KYLE L. REEVES, DDS
116 DENVER TRAIL; AZLE, TX 76020
817-444-3890 817-270-4746
www.270grin.com

Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Communication Consent Form

Patient Name:_____ Date of Birth:_____

This consent form allows Eagle Mountain Family Dental, PC to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Eagle Mountain Family Dental, PC has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. Eagle Mountain Family Dental, PC provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Eagle Mountain Family Dental, PC.

_____I hereby authorize that Eagle Mountain Family Dental, PC may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____I hereby authorize that Eagle Mountain Family Dental, PC may text message me on my cell phone to confirm appointment information (Name, time, and date).

_____I hereby authorize that Eagle Mountain Family Dental, PC may email message me to confirm appointment information (Name, time, and date). Email:_____

_____I hereby authorize that Eagle Mountain Family Dental, PC may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

_____I hereby authorize that Eagle Mountain Family Dental, PC may disclose my personal health information to the person who I have listed as my emergency contact.

_____I hereby authorize that Eagle Mountain Family Dental, PC may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Eagle Mountain Family Dental, PC services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Eagle Mountain Family Dental, PC may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future- how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Eagle Mountain Family Dental, PC is not required to agree to my requested restrictions, if it does, it is bound by that agreement.

By my signature below, I affirm the above information.

_____ _____

Signature Date