EAST BEND DENTAL

Taylor Fowles, DMD / Kelli Fowles, DMD / Mary Kate Grady, DDS

Thank you for choosing us as your dental care provider. We look forward to caring for you!

Full Name: _____ Preferred Name: _____

Marital Status: S / M / W / D Sex: M / F / Other: _____ SS#:_____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Home phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

Patient Employer: _____ Employer's Phone: (_____) _____

Person responsible if different from Patient: _____

Relationship: _____ DOB: _____

SS#: _____ Employer: _____ Phone: _____

Are you covered by **dental** insurance? Yes ☐ No ☐ Secondary **dental** insurance? Yes ☐ No ☐

CONTACT INFORMATION

Leave a message on your voicemail? Yes ☐ No ☐

Leave a message at your place of employment? Yes ☐ No ☐

Discuss your dental condition with a household member? Yes ☐ No ☐

Name: _____ Relationship: _____

Send Electronic Communication? Email ☐ text message ☐

Emergency Contact: _____ Phone: _____

PATIENT SIGNATURE (PARENT OR GUARDIAN IF MINOR) DATE

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MEDICAL HISTORY

Patient name: _____

Physician name: _____Phone: _____

Are you currently under a physician's care for medical issues? Yes □ No □

Are you taking any medications or supplements, over-the-counter or prescribed? Yes □ No □

Please list medications: Medication list attached □

_____ _____ _____

_____ _____ _____

Have you had any major operations? Yes □ No □ _____

Have you been hospitalized in the last 3 years? Yes □ No □ _____

Do you use tobacco? Yes □ No □ Do you use recreational or illegal drugs? Yes □ No □

Are you allergic or had an unusual reaction to any of the following?

□Aspirin □Penicillin □Codeine □Local anesthetic □Sulfa □Latex □Metal □Other_____

Women: Are you: pregnant □ trying to get pregnant □ nursing □

Do you have, or have you had, any of the following?

□ AIDS/HIV	□ Diabetes	□ Heart Murmur	□ Scarlet Fever
□ Alzheimer's/Dementia	□ Drug/Alcohol dependence	□ Heart Pacemaker	□ Shortness of breath
□ Anaphylaxis	□ Eating Disorders	□ Heart Stent	□ Shingles
□ Anemia	□ Emphysema	□ Hepatitis	□ Sinus Problems
□ Arthritis	□ Epilepsy	□ High Blood Pressure	□ Sleep Apnea
□ Artificial Heart Valve	□ Excessive bleeding	□ Hypoglycemia	□ STD
□ Artificial Joint	□ Fainting / dizziness	□ Jaundice	□ Stomach Problems
□ Asthma	□ Frequent cough	□ Kidney Problems	□ Stroke
□ Blood Transfusion	□ Gag Reflex	□ Liver Disease	□ Thyroid Disease
□ Blood Thinners	□ GERD/Acid Reflux	□ Low Blood Pressure	□ Tonsillitis
□ Bronchitis	□ Glaucoma	□ Mental Disorders	□ Tuberculosis
□ Cancer	□ Gout	□ Mitral Valve Prolapse	□ Ulcers
□ Chemotherapy	□ Heart Attack	□ Osteoporosis	□ Other (Please List)
□ Chest Pain/Angina	□ Heart Disease	□ Radiation Treatments	_____
□ Cold Sores	□ Head Injury	□ Respiratory problems	_____
□ Depression	□ Heart Failure	□ Rheumatic Fever	_____

Are you required by a physician to take prophylactic antibiotics prior to dental procedures? Yes □ No □
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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DENTAL HISTORY

Former dentist: _____ Approximate last visit date: _____

PLEASE SELECT ONE BOX ON EACH LINE

My dental health is: Excellent □ Good □ Fair □ Poor □
My mouth is: Very comfortable □ Somewhat comfortable □ Uncomfortable □
My smile is: Excellent □ Needing improvement □ Not of concern □
Have you ever been told you have gum or periodontal disease? Yes □ No □
Do you have significant dental anxiety? Yes □ No □
Do you sleep well at night? Yes □ No □
Do you snore? Yes □ No □
Do you wear a CPAP device or sleep appliance? Yes □ No □
Do you have severe, frequent headaches and/or muscle tension? Yes □ No □
Do you have any jaw pain, noises, or a previous diagnosis of TMJ? Yes □ No □
I want to keep my teeth: whatever it takes □ only within a certain budget of time and money □
Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain: _____
Anything else we should know? _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____

□ Another Patient _____ □ Relative □ Friend □ Dental Office □ Advertisement
□ School □ Work □ Facebook □ Yelp □ Google □ Other_____

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Financial Policy

As a courtesy to our patients, our office will file claims to the patient's insurance carrier when all current dental insurance information is provided. Our office recommends that each patient become familiar with their insurance coverage including deductibles, co-pays, and yearly maximums as each insurance company determines their own level of reimbursement. For major services, we can submit a pre-authorization, **when requested**.

Please remember, payment for professional services is the responsibility of the patient. Services are provided without the assumption they will be paid by an insurance company. **Any balance after payment by insurance is due in 30 days.** Major services require 50% patient payment at the time of service.

1. Patient payment is required at the time of service.
2. We require advance payment for all emergency patients.
3. This office does not extend personal lines of credit. Payment arrangements **MUST** be made in advance of treatment.
4. Interest will be charged on all accounts over 60 days at the rate of 1.5% (18% annually, 50¢ minimum).
5. A $35.00 service fee will be charged on all returned checks.

We accept the following methods of payment.

- Cash, personal check, or money order (5% discount)
- Visa / MasterCard / Discover / American Express / Debit Card
- CareCredit: 0% 6 or 12 months, 14.9% over 12 months
- Compassionate Finance (9.9% - 13.9% 6 - 60 months)

CANCELLATION POLICY: We request at least 48 hours notice when rescheduling or cancelling an appointment. Patient is subject to a fee of $50.00 if the appointment is cancelled with less than 24 hours notice.

I hereby authorize East Bend Dental to furnish the insured's insurance carrier(s) information that said insurance carrier may request concerning claims. I hereby assign to East Bend Dental all money to which I am entitled for expense related to the services performed from time to time, but not to exceed my indebtedness to East Bend Dental. It is understood that any money received from my insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to East Bend Dental for all charges not covered by this agreement.
If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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 to obtain a current copy of the *Notice of Private 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 health care operations. I also understand 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 patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	**Initials:**	**Reason:**