River Bend Dental (972)596-3405

Getting to Know You

Patient Information:

Patient Name	Home Address	City, State, Zip
Home Phone	Social Security # Driver's License #	Birthdate
Cell Phone	Email	Gender Male Female
Work Phone	Marital Status Single Married Divorced Other	Contact Preference Email Text Phone

Insurance Information:

Insurance Company	Group #	ID #

Insurance Subscriber Information (if different from patient):

Insured Name	Home Address	City, State, Zip
Home Phone	Social Security # Driver's License #	Birthdate
Cell Phone	Email	Gender Male Female
Work Phone	Marital Status Single Married Divorced Other	Occupation

Responsible Party (if different from patient):

Name:	Birthdate:
Social Security #	Driver's License #

How did you hear about our office? _____

Communication and Release

I hereby authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. I consent to the use of these by the doctor for scientific papers or demonstrations. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks. I understand that I can ask for a complete recital of any possible complications. I acknowledge that I have review the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my permission to this office to phone or email me to discuss my account, appointments, or treatment. If you must change your appointment, we require at least 24-hour notice to avoid a $65 per scheduled hour cancellation fee. If there is a no-call no-show for an appointment, there will be a fee of $85 per scheduled hour.

_____ _____

Patient/Parent/Responsible Party (I have read and agree to the content, terms, and conditions listed above) Date

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Financial and Insurance

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due on or before time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, to collect any debt, my credit history may be checked through use of my social security number and any other information given.

I understand that there is a $25 monthly late fee if I do not pay my balance within 30 days of a statement due date. There is a $35 processing charge for non-sufficient funds or returned checks.

I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and authorize my insurance company to pay directly to this office benefits accruing under my policy.

If the insurance company does not pay after 60 days, I understand I will become responsible for the balance and will be billed directly for the full amount due.

I understand this office will do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated and agree to pay this office in accordance with its credit terms and policy.

_____ ■ I have read the above conditions of treatment and payment and agree to their content.

_____ ■ I do not agree to the content above and/or do not want to disclose my Social Security Number. I realize this is my choice and I may still get treatment here. I further understand this comes with the following changes: 1) all treatment will need to be paid in full on or before the day of service, 2) insurance will reimburse me and not my dentist, 3) I must pay with credit card or cash, 4) no payment arrangements will be possible, and 5) often insurance cannot be verified, and estimates will be less accurate.

_____ _____

Patient/Parent/Guardian Signature (Responsible Party) Date

_____

Relationship to Patient

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Health History

NAME: _____ Date of Birth _____

Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you now or in the past:

Y N	Heart attack/Chest Pain	Y N	Implant/Artificial Joint When? _____	Y N	Thyroid Disease	Y N	Headaches or Migraines
Y N	Heart Disease			Y N	Asthma	Y N	Epilepsy/Seizures
Y N	Pacemaker	Y N	Anemia or Blood Disorder	Y N	Ulcers/Reflux/Heartburn	Y N	Cancer/Chemo/Radiation
Y N	Heart Valve Disorder	Y N	Excessive Bleeding	Y N	Digestive Disorders	Y N	Tuberculosis
Y N	Stroke	Y N	Psychiatric Disorders	Y N	Kidney/Liver Problems	Y N	Lung Problems
Y N	High Blood Pressure	Y N	Mononucleosis	Y N	Fainting or Blackouts	Y N	AIDS or HIV Infection
Y N	Diabetes	Y N	Herpes	Y N	Drug/Alcohol Dependency	Y N	Use Tobacco?
Y N	Take Blood Thinner	Y N	Osteoporosis	Y N	Glaucoma	Y N	Hepatitis A B C D

Please explain any YES response: _____

_____

_____

Y N Has your physician advised you to take antibiotics before dental treatment? Reason _____

Periodontal disease has been linked to the following. Are you are aware of any family history of : (circle all that apply)

Heart Disease Stroke Diabetes Early-Term Birth Cancer Dementia

Y N (Women) Are you currently pregnant? If yes, when is your due date? _____

Y N Have you had any surgeries or been hospitalized in the last 5 years?

If yes, please explain: _____

Physician's name and phone: _____

Please list any allergic reactions to an anesthetic or drug such as **penicillin, sedatives, latex, aspirin, or metals**:

_____

Please list any drugs, medications, supplements, or vitamins you are currently taking:

Here at River Bend Dental we offer a variety of services to enhance your comfort, and keep your smile beautiful. Please circle any service below you would like our friendly team to discuss with you during your visit.

Teeth Whitening Options	Sedation	Invisalign (Clear Braces)	Traditional Braces
Veneers	Extended Payment Plans	Headache/Migraine Therapy	Sports/night/snoring appliance

Responsible Party Signature: _____ Date: _____

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Dental History

NAME: _____ **Date of Birth** _____

Reason for today's visit _____

How often do you routinely see the dentist? ___ 3 months ___4 Months ___6 months ___ Not routinely

Please Rate your anxiety/fear of dental treatment: ___0 ___ 1-3 ___ 4-6 ___ 7-9 ___10 or more

Have you ever had an unfavorable dental experience? _____Yes _____ No

Have you ever had complications with dental treatment? _____Yes _____ No

Ever had trouble getting numb or reaction to anesthetic? _____Yes _____ No

Do you have an immediate dental concern? _____Yes _____ No
If Yes, Explain:

Bite and Jaw Joint

Do you have any problems with your jaw joint? Y N
(Pain, sounds, limited opening, locking, popping)

Do you have any problems chewing bagels, protein bars, or other hard foods? Y N

Have your teeth changed in the last 5 years? (shorter, thinner, worn out) Y N

Are your teeth crowding or developing spaces? Y N

Do you have to squeeze to make your teeth fit together? Y N

Do you have any problems with sleep, or wake up with an awareness of teeth/jaw? Y N

Have you ever worn a bite appliance? Y N

Tooth Structure

Have you had any cavities in the last 3 years? Y N

Does your mouth feel dry or do you have difficulty swallowing food? Y N

Do you feel or notice any holes, pits, or craters in your teeth? Y N

Are your teeth sensitive? (hot, cold, biting, sweets) Y N

Do you avoid brushing any part of your mouth? Y N

Do you have grooves/notches on your teeth near the gumline? Y N

Do you frequently get food caught between your teeth? Y N

Smile Characteristics

Is there anything about the appearance of your teeth you would like to change? Y N

Would you like your teeth whiter? Y N

Have you felt uncomfortable or self-conscious about your teeth? Y N

Have you ever been disappointed with appearance of your dental work? Y N

Gum and Bone

Do your gums bleed when brushing/flossing? Y N
Have you ever been treated for gum disease? Y N
Have you noticed an unpleasant odor/taste? Y N
Is there a family history or periodontal disease? Y N
Have you noticed gum recession? Y N
Do your teeth feel loose? Y N
Do you have difficulty eating? Y N
Have you ever had a burning sensation in your mouth? Y N

Signature:

_____ _____

Patient, Parent, Guardian Date:

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Financial Policy

At River Bend Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, and some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know.

- Your dental benefits are based on a contract between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for 100% completion of your dental care. It is only meant to assist you.
- We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list). This means that we work with literally thousands of companies. Although we maintain computerized histories of payment by a given company, they do change. Therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If requested, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage and it delays treatment. It will, however, give you the exact out of pocket figures you may require.
- We will bill your insurance as a courtesy. If insurance does not pay within 90 days, River Bend Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract.
- River Bend Dental does require payment in full for your portion on or before the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history).
- If you would like an extended financial option, we also work with CareCredit. We accept the 6 or 12 month "same as cash" plans and the longer-term interest-bearing revolving charge designed to meet your treatment plan and budget needs (on approved credit).
- A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24-hour notice to avoid a $65 per scheduled hour cancellation fee. If there is a no-call no-show for an appointment there will be a fee of $85 per scheduled hour.
- In the event of an emergency after regular business hours, a $55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $150 after-hours emergency fee.
- Ultimately, you are responsible for all charges incurred in our office.

I agree with the above Financial Policy.

Print Name: _____ Date: _____

Patient/Parent Signature: _____

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HIPAA

Authorization to Disclose and Share

Personal Health Information

I, _____, have been provided a copy of the Notice of Privacy Practices and hereby authorize John Bonds, DDS, PhD, and his designated staff members to review and discuss my Personal Health and Financial Account Information with the following people.

1. _____
2. _____
3. _____
4. _____
5. _____

This authorization will remain in effect until revoked in writing by me.

_____

Name

_____

Signature

_____

Date

Media Release

I do hereby give River Bend Dental, their assigns, licensees and legal representatives, the irrevocable right to use my name, picture, photograph, portrait, visual likeness, or voice in all forms and media in all manners, including photo, film, audio, and video representations, for non-profit, public purposes and I hereby waive any right to inspect or approve the finished product that may be created in connection therewith.

Print Name: _____ Date: _____

Patient/Parent Signature: _____