

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: _____ DO YOU RECIEVE TEXT? YES NO

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 # - -
MM/DAY/YR

EMPLOYER NAME _____

CARRIER NAME _____ TELEPHONE # _____

ADDRESS _____
STREET CITY STATE/ZIP

GROUP # _____ SUBSCRIBER # _____

CONSENT

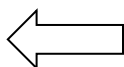
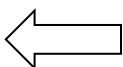
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ 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.

Acknowledgement of Receipt of Notice of Privacy Policies

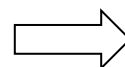
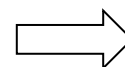
I, _____, have received a copy of
EAGLE MOUNTIAN FAMILY DENTAL, PC'S Notice of Privacy Policies.

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 emergency 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, THE CLIENT/PATIENT 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		
Heart Attack Date?	No	Yes	Other Conditions		
Heart Surgery Date?	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 dietary or herbal supplements you are taking, and for what purpose:

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



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

Today: BP _____ / _____ PULSE _____ SpO2 _____

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? Hot? Cold? Pressure?	Yes Yes Yes Yes	No No No No	Sometimes Sometimes Sometimes Sometimes
Dry Mouth	Does your mouth feel dry? Do you feel thirsty all the time?	Yes Yes	No No	Sometimes Sometimes
Gums	Do your gums bleed when you brush? Do they bleed when you floss? Do your teeth wiggle- even slightly? Have you ever had gum surgery? Have you ever had, or have you ever been recommended a "deep cleaning"?	Yes Yes Yes Yes Yes	No No No No No	Sometimes Sometimes Sometimes Sometimes Sometimes
Grinding/ Jaws	Do you have pain in your jaw joints (TMJ)? Does your jaw joint pop or click? Do you have difficulty chewing? Do you clench your teeth? Do you grind your teeth? If yes, do you wear a nightguard? <input type="checkbox"/> Yes <input type="checkbox"/> No	Yes Yes Yes Yes Yes	No No No No No	Sometimes Sometimes Sometimes Sometimes Sometimes

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

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