Welcome

Thank you for selecting **Dr. James Bond DMD** as your dental healthcare team! We will strive to provide you with the best dental care possible. **To ensure that we provide you with the most comprehensive and individualized care, please help us by completing this Welcome form, as well as the attached Medical/Dental History, Privacy Practices/Financial, and Photo Release.** Please let us know if you have any questions or need assistance – we are glad to help!

Patient Information (confidential)

Date: _____

SS#/SSN: _____

Name: _____ Phone: _____ □ Home □ Cell

Preferred name(nickname): _____ Birthdate: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

Email: _____ how do you prefer reminders? □ Phone □ Text □ Email

Emergency Contact: _____ Phone: _____

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated □ Other _____

Responsible Party

Name of Person Responsible for this Account: _____Relationship:_____

Address (□ Same): _____

Email (□ Same): _____ Phone: _____ □ Home □ Cell

Driver's License: _____ Birthdate (□ Same):_____ Financial Institution: _____

Employer: _____ Work Phone: _____ SSN (□ Same):_____

Is this person currently a patient in our office? □ YES □ NO

For your convenience, please check one of the payment options we provide listed below that you prefer:

□ Cash □ Personal Check Credit Card: □ Visa □ Master Card □ Discover □ Care Credit Financing

Insurance Information

Please Have Insurance Card & Driver's License Ready for Us to Copy

Name of Insured (□ Same):_____ Relationship to Patient: _____

Birthdate (□ Same):_____ SSN: _____ Date Employed: _____

Name of Employer: _____ City: _____ State: _____ Zip : _____

Insurance Company: _____ Group #: _____ Policy #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip :_____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit: _____

DO YOU HAVE ANY SECONDARY/ADDITIONAL INSURANCE? □ YES □ NO IF YES, COMPLETE THE FOLLOWING

Name of Insured (□ Same):_____ Relationship to Patient: _____

Birthdate (□ Same):_____ SSN: _____ Date Employed: _____

Name of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip :_____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit: _____

MEDICAL HISTORY

Patient Name_____Nickname_____Age_____
Name of Physician/and their specialty _____
Most recent physical examination_____Purpose_____
What is your estimate of your general health? (a) Excellent (b) Good (c) Fair (d) Poor

DO YOU HAVE or HAVE YOU EVER HAD:	**Y**	**N**
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to **(CIRCLE)**		
• aspirin, ibuprofen, acetaminophen, codeine _____	☐	☐
• penicillin, erythromycin, tetracycline, _____	☐	☐
• other antibiotic _____	☐	☐
• local anesthetic _____	☐	☐
• fluoride_____	☐	☐
• metals (nickel, gold, silver, other) _____	☐	☐
• latex _____	☐	☐
• other_____	☐	☐
3. heart problems or cardiac stent within last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (Total Joint) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR>3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis_____	☐	☐
14. tuberculosis, measels, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	☐	☐
17. kidney disease_____	☐	☐
18. liver disease_____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency ____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c: _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	Y	**N**
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
27. arthritis, rheumatoid arthritis, lupus _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses_____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. STI/STD _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy, immunosuppressive _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol (amount per week) _____	☐	☐
46. recreational drugs _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, diarrhea) _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)		
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches _____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco (If yes, how much) _____	☐	☐
53. considered a touchy person_____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE – pregnant _____	☐	☐
57. MALE – prostate disorders_____	☐	☐

Describe any **current medical treatment, impending surgery**, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for additional Sheet if taking more than 6 medications or bring in list

Patient's Signature_____ Date _____

Doctor's Signature _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

James Bond Family Dentistry
Pediatric Informed Consent

Patient's Name:_____Date:_____

I give my consent for Dr. James Bond and staff to perform the following initial procedures on my child:

Please place your initial next to all that you consent to during your child's first exam:

_____prophylaxis (dental cleaning)
_____fluoride treatment
_____radiographs (x-rays), as recommended by the dentist
_____an exam
_____sealants as needed for my child
_____Intraoral/Extra oral Photographs

I understand that refusal of any procedures above could result in an incomplete diagnosis or treatment of my child.

_____ _____ _____
Parent/ Legal Guardian Signature Date Witness Signature

THE FOLLOWING IS A LISTING OF RECOMMENDED TREATMENT(S) AND A LISTING OF THE COMMON RISKS OR COMPLICATIONS ASSOCIATED WITH SUCH TREATMENT(S). PLEASE ASK ANY QUESTIONS PRIOR TO SIGNING THIS FORM.

YOUR SIGNATURE ON THIS FORM INDICATES THAT YOU UNDERSTAND THE NATURE OF THE PROPOSED TREATMENT, THE RISKS AND ALTERNATIVES TO SUCH TREATMENT AND THE CONSEQUENCES OF NOT UNDERGOING TREATMENT. YOU ALSO INDICATE THAT ALL YOUR QUESTIONS HAVE BEEN ANSWERED TO YOUR SATISFACTION AND THAT YOU BELIEVE IT TO BE IN YOUR CHILD'S BEST INTEREST TO PROCEED WITH THE PROPOSED TREATMENT. PLEASE NOTE IT IS NOT POSSIBLE TO PREDICT OR GUARANTEE THE OUTCOME OF ANY TREATMENT(S). PROPOSED TREATMENT MAY ACTUALLY CHANGE DUE TO THE PATIENT'S ACTUAL DENTAL CONDITION AT THE TIME OF TREATMENT.

Proposed treatment: Resin "plastic" sealant, resin composite restoration (tooth colored filling), pulp caps (medicated covering of an exposed pulp/nerve due to deep decay) pulpotomy (partial removal of tooth nerve), pulpectomy (total removal of tooth nerve), stainless steel crown, extraction, space maintainer, composite crown.

Benefits and alternative treatments: Removing decay and restoring or removing teeth or placing space maintainers allows your child's oral health to become optimal. This allows for better mastication (chewing), speech, and overall health. It also helps the permanent teeth to erupt in a more favorable position. Pulpotomies and fillings/stainless steel crowns aim to keep your child's tooth until its natural loss. The alternatives include observing the decay (doing nothing, although this may allow the decay to continue and possibly lead to infection and/or space loss/extraction), extracting the decayed tooth and placing a space maintainer, if recommended. All alternatives require compromises that may affect your child's overall dental and medical health.

Common risks: The more common risks include but are not limited to: allergy to local anesthetic or the restorative materials used (although such allergies are rare), biting the cheek, lips or tongue when numb, allergy to latex used in dental gloves and rubber dam, infection (either prior to or after removing decay and restoring the tooth with a filling or a pulpotomy and filling/stainless steel crown), future decay/treatment failure, tooth loss, paresthesia (partial or total numbness, lasting from a few days up to permanent numbness), sensitivity to temperature, and/or space loss. Orthodontic consult and treatment may be necessary prior to or after treatment.

Consequences of not performing treatment: The more common consequences of not performing treatment are that the decay process will continue and more teeth will be affected. Deep decay can cause infection and subsequent premature tooth loss. Decayed teeth become reduced in size, which may cause space loss necessitating orthodontic therapy.

I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be ***safely*** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements. **I further understand** that should the patient become uncooperative during dental procedures, temporary fillings may be placed and your child may be referred to a pediatric dentist for continuation of care.

For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic and education purposes, as well as collaboration of care with referring specialists.

Every reasonable effort will be made to ensure that your child's dental condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, benefits, alternatives and risks of procedure(s) and the consequences of not performing the procedure(s), that you understand this information and that all your questions have been answered fully. I further understand that parents must remain in the reception area for the duration of their child's visit. However, for the initial visit, that parent will accompany the child to the consultation area. Upon completion of consultation, the parent will be requested to return to the reception area.

Proposed Treatment (please see treatment plan page):_____

_____

- ❑ **I give my consent for the proposed treatment as described above.**
- ❑ **I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision to refuse treatment.**

_____
Patient's Name

_____
Parent/Legal Guardian's Signature Date

_____
Dentist's Signature Date

James Russell Bond DMD P.C. dba James Bond Family Dentistry

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 7/23/2015, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;

- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: James Bond DMD

Telephone: 406-586-5008 Fax: 406-587-6181

Address: 45 W Kagy Blvd Suite 4, Bozeman MT 59715

E-mail: office@jamesbonddental.com

Financial, Privacy and Cancellation Policies

The Doctor(s) at James Russell Bond DMD PC (DBA James Bond Family Dentistry) along with the entire team, are pleased that you have chosen us for your dental care. We would like to make you aware of our Financial & Acceptance of Insurance Assignment Policies and would appreciate your cooperation. Please review and sign.

* Cash Patients: Payment will be **DUE AT THE TIME OF TREATMENT** and may be paid by any one of the options listed below.
* Patients with Insurance Plans: There are so many different insurance plans that it is impossible for us to know what your plan covers. Because of this, we are considered an out-of-network provider for all dental insurance plans. As a service to our patients, we will submit insurance claims at no charge. We will do all we can to assist you in determining your coverage and maximizing your allowable benefits. However, the estimated co-payment and deductibles, as well as the portion estimated not to be paid by the plan, are due at the time of service. If your insurance plans pays you directly, then the full balance is due at time of service. Please see our payment options below.
* Flex/Cafeteria Plans: Payment in full is **DUE AT THE TIME OF TREATMENT**. We will provide a "paid" receipt for Flex reimbursement to you.
* For all accounts: Outstanding 60 days or more, 10% APR will be applied to monthly billing statements. Accounts 90 days or more are subject to collection proceedings unless other arrangements have been made to clear the account. Interest rate may change without notice.
* Collections: **All accounts turned over to collections will incur additional fees due directly to the collection agency.**

We accept cash, checks (to patients of record), debit cards, MasterCard, Visa, Discover and American Express.

We are happy to offer **Care Credit** and **Compassionate Finance** as two financing options available to assist you if you need to make extended payments. It is necessary to fill out an application. **If interested, please ask us for more details**. These options are subject to change without notice.

Please Initial Boxes:

☐ I acknowledge that I have been informed of James Russell Bond DMD PC's financial policy outlined above. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize my insurance company to pay directly to James Russell Bond DMD PC insurance benefits otherwise payable to me, unless I ask to pay for treatment in full and receive a benefit check directly. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Privacy Policy

☐ I acknowledge that I have been informed of James Russell Bond DMD PC's Notice of Privacy Policies. A copy has been made available to me at www.jamesbonddental.com and at the front desk.

Cancellation Policy

☐ I acknowledge that appointments are considered confirmed when they are made. Our office requires **TWO** business days notice for appointment change requests. This includes changes in time, date, treatment, provider, or appointment cancellation. Please note that should you leave a request for change via voicemail, text or email when our office is closed, we will consider the request to have been made on the following business day. Should you fail to give the required **TWO** business days notice for appointment changes, you will be charged a fee. This fee could be up to and including the full fee for the appointment you changed, cancelled, or missed.

Signature _____ Date _____

45 W Kagy Blvd Suite 4, Bozeman MT, 59715 Phone: 406.586.5008 Fax: 406.587.6181