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.

DENTAL HISTORY

Name_____

How would you rate the condition of your mouth? (a)Excellent (b)Good (c)Fair (d)Poor

Referred By_____ Previous Dentist _____

How long were you a patient? _____ Last Cleaning?_____

Type of Cleaning? _____ Did you get X-rays (type)? _____

When was your last dental treatment (What was it)?_____

I routinely see my dentist every: (a) 3 mo. (b) 4 mo. (c) 6 mo. (d) 12 mo. (e) Not routinely

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?_____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?_____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
10. Is there anyone with a history of periodontal disease in your family?_____	☐	☐
11. Have you ever experienced gum recession?_____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?_____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?_____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?_____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, had a toothache or cracked filling?_____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____	☐	☐
25. Are your teeth crowding or developing spaces? _____	☐	☐
26. Do you have more than one bite position and/or need to squeeze to make your teeth fit together?_____	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	☐	☐
28. Do you clench your teeth in the daytime or make them sore?_____	☐	☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth?_____	☐	☐
30. Do you wear or have you ever worn a bite appliance?_____	☐	☐
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change?_____	☐	☐
32. Have you ever whitened (bleached) your teeth?_____	☐	☐
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth?_____	☐	☐
34. Have you been disappointed with the appearance of previous dental work?_____	☐	☐

Patient's Signature_____Date_____

Doctor's Signature_____

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

James Russell Bond DMD PC
DBA James Bond Family Dentistry
45 W Kagy Blvd. Suite 4
Bozeman, MT 59715

Patient Photo Release Form

(Adult Patients Only)

I hereby authorize Dr. Bond or any of his assignees to take photographs and/or videos of my face, jaws, and teeth.

I understand that the photographs and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising/marketing and professional publications (dental magazines and journals).

I further grant the release to use and reuse, in any manner; photographs/videos, slides, dental casts, radiographs, personal health information including diagnostic information, used in whole or in part within a lecture or educational setting, I do not expect compensation, financial or otherwise, for the use of these photographs.

I hereby release and discharge Dr. James Bond and assignees from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for invasion of privacy or libel.

Please initial:

_____I approve the **anonymous use** of my photographs/information as stated above.

Exception (Please initial if applicable):

_____I **do not** wish to have my photos used at all.

Patient Name _____

Patient Signature_____

Date_____