# LARAWAY FAMILY DENTISTRY

## Patient Information

Today's Date:_____

Patient's Name:_____
Last First MI

I prefer to be called:_____

Whom may we thank for Referring you?:
_____

Social Security #:_____

If Child, Parent's Name:_____

Driver's License #:_____

Emergency Contact Not Living With You:
_____

Date of Birth:_____Male:_____ Female:_____

Single:___ Married:___ Divorced:___Widowed___ Minor:___

Address:_____

City:_____ State:_____ ZIP:_____

Phone: (H)_____ (W)_____

Cell:_____ Pager_____

E-Mail Address:_____

Employed By:_____

Spouse's Name:_____

Spouse's Social Security #:_____

Spouse Employed By:_____

Dental Insurance Coverage:

Employee Name:_____

Employer:_____

Insured's Social Security #:_____

Telephone:_____

Program or Policy #:_____

Group #:_____

Claims Mailing Address:_____
_____
_____

This office no longer accepts secondary insurance. However, we will assist in providing you with a statement of treatment rendered for you to submit to your secondary insurance company for direct reimbursement.

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**PATIENT RELEASE**

I authorize each of the following:

1. The Dentist to perform diagnostic procedures and treatment necessary for proper dental care. The Dentist to perform any emergency medical procedures, if necessary.
2. The release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
3. The release of any information or x-rays concerning my (or my child's) healthcare, advice and treatment to another dentist in accordance with HIPAA regulations.
4. Payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental insurance may pay less than the actual charges for services. I understand I am financially responsible for payment in full on all accounts. I further understand that I am responsible for knowing and understanding the benefits and limitations of my dental plan coverage.

Patient or Guardian's Signature:_____ Date:_____

(Continued on Back Side)

# Medical/Dental History

Patient's Name:_____

NOTES

| | Y/N |
|---|---|
| 1. Are you having pain or discomfort at this time? | ☐☐ |
| 2. Do you feel you currently have cavities or gum disease? | ☐☐ |
| 3. Are any of your teeth or fillings loose or broken? | ☐☐ |
| 4. Are you ever concerned about bad breath or halitosis? | ☐☐ |
| 5. Do you brush on a daily basis? | ☐☐ |
| 6. Do you floss on a daily basis? | ☐☐ |
| 7. Do you have any sensitive areas to hot, cold, sweet or pressure? | ☐☐ |
| 8. Do you feel nervous about having dental treatment? | ☐☐ |
| 9. Are you interested in having whiter teeth? | ☐☐ |
| 10. Is there anything you wish to change about your smile? | ☐☐ |
| 11. Have you ever been under the care of a medical doctor in the past two years? | ☐☐ |
| 12. Are you currently taking any medication, drugs or pills? | ☐☐ |

If yes, Please list those drugs including over the counter and herbal remedies:

_____

13. Circle if you have ever had any adverse reactions to any of the following:

| | | | |
|---|---|---|---|
| Aspirin | Nitrous Oxide | Penicillin | Demerol |
| Darvon | Valium | Erythromycin | General Anesthesia |
| Codeine | Percodan | Tetracycline | Vicodine/Hydrocodone |
| Fluoride | Metals | Local Anesthetic | Nococain/Xylocaine |

14. List any other medications or substances to which you are allergic:

_____

15. Check the yes or no box in front of each condition if you have had in the past or currently have any of the following:

| Y/N | Y/N | Y/N | Y/N |
|---|---|---|---|
| ☐☐ Heart Problems | ☐☐ Pacemaker | ☐☐ Anemia | ☐☐ Persistent Cough |
| ☐☐ Blood Transfusions | ☐☐ Rheumatic Fever | ☐☐ Kidney Trouble | ☐☐ Tuberculosis |
| ☐☐ Heart Surgery | ☐☐ Scarlet Fever | ☐☐ Excessive Thirst | ☐☐ Emphysema |
| ☐☐ Angina Pectoris | ☐☐ Sickle Cell Disease | ☐☐ Frequent Urination | ☐☐ Hay Fever |
| ☐☐ Heart Attack | ☐☐ Bruise Easily | ☐☐ Diabetes | ☐☐ Asthma |
| ☐☐ Heart Murmur | ☐☐ Immunocompromised | ☐☐ Hepatitis | ☐☐ Shortness of Breath |
| ☐☐ High Blood Pressure | ☐☐ Organ Transplant | ☐☐ Jaundice | ☐☐ Sinus Trouble |
| ☐☐ Low Blood Pressure | ☐☐ Ankles/Legs Swell | ☐☐ Cortisone Treatments | ☐☐ Allergies/Hives |
| ☐☐ Artificial Heart Valve | ☐☐ Ulcers | ☐☐ Liver Disease | ☐☐ Cold Sores |
| ☐☐ Mitral Valve Prolapse | ☐☐ Arthritis, Rheumatism | ☐☐ Substance Abuse | ☐☐ Thyroid Condition |
| ☐☐ Hemophilia | ☐☐ Hypoglycemia | ☐☐ Tobacco Habit | ☐☐ Artificial Joints |
| ☐☐ Cancer or Tumor | ☐☐ Chemotherapy | ☐☐ Radiation Treatment | ☐☐ Stroke |
| ☐☐ Fainting/Dizzy Spells | ☐☐ Epilepsy/Seizures | ☐☐ Glaucoma | ☐☐ Psychiatric Treatment |
| ☐☐ Frequent Headaches | ☐☐ Popping/Clicking Jaw | ☐☐ Grind/Clench Jaw | ☐☐ Heart Disease |

16. List ANY other disease, condition or problem not listed:_____

NOTES

| | Y/N |
|---|---|
| 17. Do you know or has anyone told you that you snore? | ☐☐ |
| 18. Do you ever wake up from sleep short of breath? | ☐☐ |
| 19. Are you on a special diet or have you ever taken the drugs Redux or Phen Phen? | ☐☐ |
| 20. Are you taking or have you ever taken a bisphosphonate drug (Fosamax/Actonel)? | ☐☐ |
| 21. Have you had any previous hospitalizations or significant surgeries? | ☐☐ |
| For Women Only: | |
| 22. Are you pregnant? If Yes, what month?_____ | |
| 23. Are you taking birth control pills? | ☐☐ |

I attest to the accuracy of the answers given on this form:

Patient's/Guardian's Signature:_____ Date:_____

2.

# Laraway Family Dentistry

## Office and Financial Policy

Patient: _____ Date: _____

Welcome, and thank you for choosing Laraway Family Dentistry for your dental care. We are dedicated to providing the highest quality dentistry in an efficient, caring and comfortable environment. So that we may help you to avoid any frustration or misunderstanding regarding our office policies, we have prepared the following summary for you. We are confident that you will experience dental excellence with our office.

_____Initial **BROKEN APPOINTMENTS AND LATE CANCELLATIONS:**

You are very important to us therefore your appointment is specifically reserved for you. We do not double book as some offices do. Broken appointments result in the loss of valuable time where we could have served another patient. There will be a **$75** fee assessed for any appointments missed or cancelled without **48** hours in advance with the **Hygienist** and **$150** with the **Doctor.** We do our best to remain on schedule. When patients arrive late for their appointment, it is impossible for us to stay on schedule. So for those who show up late **15** min or more to their appointments will be rescheduled and possibly charged a **$75** late fee. Please help us to avoid these fees by keeping your scheduled appointment.

_____ Initial **INSURANCE:**

We must emphasize, that as dental providers, our relationship is with you, the patient, not your insurance company. **Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.** We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **YOU ARE FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY YOUR INSURANCE COMPANY.** We charge what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **NOTE WE DO NOT FILE WITH SECONDARY INSURANCE BUT WE MAY PREPARE A CLAIM FOR YOU SO THAT YOU MAY IT SUBMIT YOURSELF TO YOUR SECONDARY INSURANCE.**

_____ Initial **PAYMENTS AND BALANCES:**

We accept **CASH, CHECKS AND MOST MAJOR CREDIT CARDS.** If for any reason a check is returned by the bank unpaid, we will add **$50** to your original balance. We also work with Care Credit financing options. We can assist you in the application process for both. Ask us about our In House Benefit program, which is non refundable. **It is your responsibility to provide us with your most current billing information**. You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information. **Payment in full is due upon receipt of the statement**. Patient balances not paid in full within **30** days of statement issue date are deemed past due. **Past due accounts may be subject to an $8 monthly fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection cost incurred, including attorney fees and court cost if applicable. Failure to keep your account balance current may require us to cancel or reschedule your appointment. **If your account is assigned to a collection agency you will no longer be able to receive services from Laraway Family Dentistry.**

_____ Initial **SCHEDULING:**

When scheduling any appointment, **patients will need to pay at least half if not all of their portion at the time of booking appointment.** When a patient decides that he/she would like to be sedated we will collect sedation fee in full at the time of booking.

_____ Initial

**TO PROTECT YOUR PRIVACY AND OTHERS CELL PHONES MUST BE ON SILENT OR TURNED OFF WHILE IN THE OPERATORY.**

_____ Initial

**FOR YOUR SAFTEY AND OURS, ONLY THE PATIENT UINDER GOING TREATMENT IS ALLOWED IN THE OPERATORY.**

_____ Initial

**ALL APPOINTMENTS MUST BE CONFIRMED VIA TEXT, CALL OR E-MAIL; ALL UNCONFIRMED APPOINTMENTS ARE REMOVED FROM APPOINTMENT BOOK.**

**I have read and understood the above policies and agree to abide by them.**

Signature: _____ Date: _____

# Laraway Family Dentistry

## Notice of Privacy Practices

You understand that, as part of the provision of healthcare services, the doctor creates and maintains health records and other information describing among other things, your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. You have been provided with a notice of privacy practices that provides a more complete description of the uses and disclosures of certain health information. You understand that you have the right to review the notice prior to signing this consent. You understand that the doctor reserves the right to change his/her notice and practices and prior to implementation will mail a copy of any revised notice to the address you have provided. You understand that you have the right to object to the use of your health information for directory purposes.

You understand that you have the right to request restrictions as to how your health information may be used or disclosed to carry out treatment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the doctor is not required to agree to the restrictions requested. By signing this form, you consent to the use and disclosure of protected health information about the patient for the purpose of treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where disclosures have already made in reliance on your prior consent.

This consent is given freely with the understanding that : a) Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without your prior written authorization, except as otherwise provided by law b) a photocopy or fax of this consent is as valid as the original c) You have the right to request that the use of your Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. You also understand that the doctor and you must agree to any restriction in writing that you request on the use and disclosure of your Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of your Protected Health Information, which have been previously agreed upon.

_____ _____

Patient print name date

_____

Patient signature

# Laraway Family Dentistry

## DOCTOR-PATIENT ARBITRATION AGREEMENT

The doctor ("Doctor") and the undersigned patient ("Patient") have agreed:

**Article 1: Agreement to Arbitrate**: The parties to this agreement are Doctor and Patient. It Is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission of arbitration and not by a lawsuit or resort to court process except as state law provides for judicial review or arbitration proceedings. **BOTH PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.**

**Article 2: All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of the related treatment of services provided by the Doctor including any spouse or heirs of the Patients and any children, whether born or unborn, at the time of the occurrence giving rise to any claim in the case of any pregnant mother. The term "Patient" herein shall mean both the mother and the mother's expected child or children.

**THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION** in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to an Arbitrator who is a dentist licensed in the state of Texas.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the Doctor's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filling of any action in any court by the Doctor to collect any fee from the Patient shall not waive the right to compel arbitration of any medical malpractice claim. However, following the assertion of any claim against the Doctor, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

**ARTICLE 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days thereafter. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joiners in this arbitration of any person or entity which would otherwise be a proper additional party in any court action, and upon such intervention and joiners any existing court action against such additional person or entity shall be stayed pending arbitration.

**ARTICLE 4: Payment of Arbitration Costs:** The prevailing party in any arbitration pursuant to this agreement shall be awarded all costs, including reasonable attorney's fees and the arbitrator fees, in prosecuting or defending the claim in arbitration, but not to exceed, $2,500 in amount. Furthermore, if any action is undertaken to set aside or otherwise attack the binding arbitration award, the losing party in the court action shall bear all the prevailing party's costs, including reasonable attorneys' fees.

**ARTICLE 5: Future Services:** This agreement shall govern all future services rendered to Patient by Doctor and Doctor's Partners, Affiliates, and Associates. Execution of this agreement is a precondition to the furnishing of services by Doctor, but this agreement may be rescinded by written notice by either party within thirty days of signature. After those thirty days, this agreement may be changed or revoked only by a written revocation signed by both parties.

**IT IS UDNERSTOOD BY THE PATIENT THAT HE OR SHE IS NOT REQUIRED TO USE THE UNDERSIGNED DOCTOR AND THAT THERE ARE NUMEROUS OTHER DOCTORS IN THE IMMEDIATE AREA WHO ARE QUALIFIED TO PROVIDE THE SAME SERVICES.**

**ARTICLE 6: General Provisions:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable state statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with procedure prescribed herein with reasonable diligence.

**ARTICLE 7: No Other Representation:** Except for the fact that the Doctor has indicated professional services will not be rendered to Patient unless this agreement is executed, the Doctor has made no other representation statements, oral or written to induce patient to execute this agreement.

**ARTICLE 8: Revocation:** This agreement may be revoked by written notice delivered to the Doctor within 30 days of signature and if not revoked will govern al medical services received by patient.

**ARTICLE 9: Retroactive Effect:** If a Patient intends this agreement to cover services rendered before this date it is signed (for example, emergency treatment) Patient should initial below. Effective as of the date of first Doctor Services.

_____

Patients Initials

If any provision of this Doctor Patient Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the individual of any other provision

**THIS IS A BINDING LEGAL, DOCUMENT WHICH MAY HAVE AN IMPORTANT EFFECT ON YOU LEGAL RIGHT, CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.**

**NOTICE: BY SIGINING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT BY TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

_____ _____

Name of Doctor Patient-Print Name Date

_____ _____

Doctors Signature or Authorized Representative Date Patient's Signature Date

_____ _____

Translated By (If Applicable): Print name Signature of Patient's Agent or Legal Representative, Date

_____ _____

Signature of Translator Date Relationship to Patient

Laraway Family Dentistry

114 Vision Park Blvd. Suit 200

The Woodlands, TX 77384

936-321-1477

# Patient Text Message Consent Form

Patient Name: _____

Patient D.O.B. _____

Cell phone number: _____

I hereby give my consent for Laraway Family Dentistry to send text message reminders to my mobile telephone (as per the above number). These messages will be a reminder of my previously scheduled appointment date and time, or a notification that I need to schedule an appointment. Please note that we accept incoming text messages.

Signature: _____ Date: _____

# Laraway Family Dentistry

Welcome to Laraway Family Dentistry and thank you for allowing us to treat your dental necessities. Here at Laraway our doctors are highly educated in other oral complications and not just teeth, these include the following:

1. TMD- (jaw joint related issues)
2. SLEEP APNEA
3. BRUXISM- (clinching and grinding)

All of these subjects are related to the overall health and quality of your teeth. Our doctors love to inform before they perform so that all of our patients get the best quality in the standard of care. We have found that in some cases some patients would much rather treat the source of their problem and others would prefer to just treat their chief complaint (only reason you are here). So please let us know which applies to you so that we may serve you best.

_____. YES, I am interested in knowing all the facts to the overall health of my teeth.

_____. NO, I am NOT interested and would ONLY like to treat my chief complaint.

I have and read and understood fully and stand strongly behind my decision.

_____ _____

Patient print name date

_____

Patient signature

_____ _____

Doctor signature date

0.9.8