2646 E. Joyce Blvd Suite 1 Fayetteville, AR 72703 Phone: 479.443.8009 Fax: 479.443.4450

Patients name: _____ Preferred Name: _____ ☐ Male ☐ Female
First Middle Last

Home Address: _____
Street Apt # City State Zip Code

Date of Birth: ____/____/____ Social Security No: _____-____-_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ Email Address: _____

Best Way to Contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Employer/School: _____ Occupation: _____ Work Phone: (_____) _____-_____

Emergency contact: _____ Relationship: _____ Phone: (_____) _____-_____

Who may we thank for referring you? _____ Names of Children/Siblings: _____

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as Above ☐ Other (**please fill out the following information**)

Name: _____ Relation to Patient: _____
First Middle Last

Home Address: _____ Phone: (_____) _____-_____
Street Apt # City State Zip Code

Date of Birth: ____/____/____ Social Security No: _____-____-_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed

Employer: _____ Occupation: _____ Work Phone: (_____) _____-_____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No
(If you do have insurance, please complete this section OR a copy of your dental insurance card is required)

Name of Insurance Subscriber: _____ Phone: (_____) _____-_____
First Middle Last

Address: _____
Street Apt # City State Zip Code

Date of Birth: _____/_____/_____ Social Security No: _____-____-_____ Employer: _____

Dental Insurance Company: _____

Member ID: _____ Group: _____ Phone: (_____) _____-_____

MEDICAL AND DENTAL HISTORY

Patient's Previous Dentist: _____ Last Cleaning Date: _____
Patient's Physician Name: _____ Last Physical Exam Date: _____

Please check ☑ if **"YES"** to every question appropriate and describe (use space at bottom of page if necessary)

PRIMARY DENTAL CONCERNS

☐ Continued Care/Cleaning/X-Rays
☐ Appearance: ☐ Straightness ☐ Chipping ☐ Color ☐ Size/Shape
☐ Functional: ☐ Decay ☐ Missing Teeth ☐ Bite ☐ Pain
☐ Toothache: ☐ Right ☐ Left ☐ Top ☐ Bottom
☐ Generalized Sensitivity ☐ Localized Sensitivity

DENTAL HISTORY

☐ Dental X-Rays taken within the last year?
When and Where?_____
☐ Have you had any Oral Surgery done? (year)_____
☐ Consulted for Orthodontic Therapy? (year)_____
☐ Treated with Orthodontic Treatment? (year)_____

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DENTAL HISTORY

□ Do you place a high priority on keeping your teeth?_____
□ Do you floss your teeth? _____ How often?_____
□ Brush your teeth? _____ How often? _____
□ Do you have an electric toothbrush?
□ Bleeding Gums? _____Treated for gum disease?_____
□ Bad Breath? _____Unpleasant Taste?_____
□ Gag Easily
□ Difficulty getting numbed with anesthetic
□ Tongue Thrusting habit
□ Suck your Thumb/Lip/Finger?
□ Fever Blisters? (Cold Sores)_____per year
□ Mouth Ulcers (Canker Sores)_____per year
□ Tooth Sensitivity: □ Hot □ Cold □ Sweets □ Chewing
□ Excessive Fear of Dental Treatment?

JAW JOINT CONDITION

□ History of TMD (jaw joint) problems
□ History of TMD Therapy performed
□ Jaw pain: □ popping □ catching □ locking of jaw
□ Clenching teeth
□ Wake up with sore jaw muscles
□ Frequent Headaches (_____ day, week, month)
□ Ear Problems □ dizziness □ aches □ ringing
□ Tenderness/Stiffness: □ jaw □ neck □ back
Please elaborate if necessary:_____

MEDICAL HISTORY

□ **Drug Allergies/Intolerance:** □ YES □ NO
If your answer is YES, please list:

_____

□ **LATEX allergy**
□ Other Allergies, Please List:

_____

List ALL CURRENT Medications:

_____

_____

□**Osteoporosis Medication:**_____
****PREFERRED PHARMACY:**

_____

List previous surgeries/hospitalizations:

_____

□ **PREMEDICATE with Antibiotics Before Dental Treatment**
□ Heart Trouble: □ Murmur □ Mitral Valve Prolapse
If other please list: _____
□ Heart Valve Replacement □ Other:_____
□ Chest Pains □ Heart Attack □ By-Pass Surgery Date:_____
□ **High Blood Pressure** □ Congestive Heart Failure □ Stroke
□ Pacemaker
□ **Take Coumadin or any other Blood Thinners:** _____
□ Prosthetic Device: □ Hip □ Pins/Plates/Screws other:_____
□ Pain Management Contract: _____
□ **Hepatitis** (circle): A B C
□ Bleeding Disorder/Anemia/Bruise Easily
□ Neurological: □ Epilepsy □ Convulsions □ Seizures
□ Psychiatric Therapy: □ Emotional Problems
□ Lung Condition: □ Asthma □ Emphysema □ Bronchitis
□ Tuberculosis □ other:_____
□ Rheumatic Fever □ Rheumatic Heart Disease
□ Liver Disorder
□ Gastrointestinal: □ Ulcers □ Stomach Problems □ **Diuretics**
□ Diabetes: □ type 1 □ type 2
□ Arthritis: □ Rheumatoid Arthritis □ Osteoarthritis
□Taking NSAIDS
□ Liver Problems
□ Thyroid problems: □ Hyperactive □ Hypoactive □ Removed
□ **Cancer** (Type, Date, Treatment):

_____

□ Radiation/Chemo or Surgery Date:_____
□ Contact Lens User/Glaucoma
□ Tested for Blood Disease: □ Hemophilia
□ Sexually Transmitted Disease:_____
□ **HIV/AIDS Positive**
□ Pregnant □ Possibly Pregnant □ Nursing
□ Taking Birth Control Pills
□ Connective Tissue Disease
□ Other Serious Illness not Listed:_____

SOCIAL HISTORY

Drink: □ Coffee □ Soda □ Tea (____ per day)
□ Use tobacco (type and amount per day):_____
□ Drink alcoholic beverages (___ per day/week)

I authorize the doctor or other dentists and health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatments as may be necessary for proper dentofacial care. The above information is accurate and complete to the best of my knowledge:

Patient/Guardian Signature: _____ Date: _____

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AUTHORIZATION FOR DENTAL TREATMENT

I herby authorize and direct the provider, and whomever she may designate as her assistant, to administer such treatment as necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained and therefore release, discharge, covenant not to sue and agree to hold harmless Dr. Kellie E. Barnes and her staff from all liability. I also certify that I have read and fully understand the above authorization for dental treatment.
Please sign below indicating that you authorize dental treatment.

APPOINTMENT REQUIREMENTS

Please understand the necessity of keeping your appointments with our office. It is very important that you keep your appointment and arrive on time. **If cancellation is unavoidable, 24 hour notice is required. Please be aware that missing or late cancelling 3 [three] appointments (without 24 hour notice) will result in you being dismissed as a patient.** If you are more than 10 minutes late- there may not be enough time for you to still be seen and will be considered a late notice cancellation. It is not our intent to be difficult. When a patient misses an appointment, it is too late to fill that time slot. Therefore, another patient needing treatment went without care. Please be considerate of our office and the community of NW Arkansas. Thank you.
Please sign below indicating that you are aware of our appointment requirements.

STATEMENT OF FINANCIAL RESPONSIBILITY

It is my responsibility to report any changes in financial abilities, insurance, address or phone number.
Failure to pay on my account could result in my being dismissed as a patient, and result in being turned over to a collection agency. I hereby authorize Kellie E. Barnes, DDS to furnish all information regarding my dental history, diagnosis and treatment or my children (if applicable) to an insurance company regarding claims for benefits. If, however, said insurer fails to meet this obligation in whole or part, or if I am not insured, I agree to be responsible for the fees and costs involved in the treatment. We strive to give you an accurate estimated out-of-pocket cost based on the information provided by your insurance company (if applicable), but there is NO guarantee of payment. We accept all dental insurance plans but are only **In-Network with Delta Dental, Arkansas BCBS, Cigna Dental and Arkansas Medicaid**. I authorize payment of dental benefits to Kellie E. Barnes DDS. I hereby authorize Kellie E. Barnes DDS to act on my behalf in accessing any records when and if I need them.
Please sign below indicating that you are aware of your financial responsibility.

By signing below, you are stating that you have read and understand all of our office policies and procedures as listed. Signature is required.

_____ _____

Patient/Guardian Signature Date

Note: Authorization must be signed by the patient, guardian or legally authorized representative.

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Acountability Act---- 45 CFR Parts 160 and 164)

I _____ consent for the office of Barnes Family Dental to share my personal information with the following: (family, friends, etc.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

I have received a copy of the Kellie Barnes Notice of Privacy Practices (HIPAA form) * Expires within 3 years of signature date.

- If you did not receive a copy, and would like one, please ask any of our office staff.

_____ _____

Signature of Patient Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtained the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____