Our mission at Keene Family Dental Clinic is to help the communities we serve through moral, thoughtful, compassionate, and superior dental care. Whether you need Preventative Care, Orthodontic, Cosmetic Dentistry, or Oral Surgery, you will be in Great hands. We believe that your health is very important, so we make it affordable to all… "Your dental dreams we can make reality". We practice Dentistry with 100% Integrity, Love and Passion, you will be in Great hands. WE TREAT, GOD HEALS

About You

First Name: ____________________ Last Name: ______________________ Preferred Name: ________________
Birthday: _____________ Gender: M__ F__ Married: __Y __N Social: _________________
Contact Info Email: ____
Mobile Phone: ____________________ Secondary Phone: ________________________

Preferred Contact Method: ____Mobile Phone __Secondary Phone __Email
Address:____ City:______________
State:__________ Zip Code:_____________

Insurance Policy

Subscriber Name:________________________ Subscriber ID#:__________________ Insurance Company:______________________ Phone#:_______________________ Employer:____________________
Group Name: ______________ Group#:______________
Relationship to subscriber: ____Self ____Spouse ____Child

How did you hear about us? _________________________

Privacy Policy

In the event that you may want a family member or friend to discuss your dental treatment with our office, we must have permission/consent to discuss your information such as x-rays, account information, treatment, etc.

If you do not wish to give consent to any person, please check the section below, sign and date the bottom portion of this form. You must choose one option.

If the patient is a minor, we will discuss dental treatment with either parent or guardian.

☐ I hereby give permission/consent to Keene Family Dentistry to discuss all dental information with the named individuals below:

Name: _________________Phone Number: _______________ Relationship: _______________

Name: _________________Phone Number: _______________ Relationship: _______________

☐ I do not wish Keene Family Dentistry to discuss any of my dental treatment with anyone other than me.

____ ____________________
Please Sign Here Todays Date

Operations Manager
Laura Gutierrez
11/21/2022

HEALTH HISTORY

First Name: ___________________ Last Name: ________________ Birthdate: ___________________

Name of Doctor: _________________________ City/State: ___________________

Emergency Contact: ___________________ Phone: ________________ Relation: _________________

List all medications you are now taking (include pills, drugs, blood thinners, etc.):

____

Are you allergic to any of the following?

Do you have any of the following medical conditions?

☐ Anesthetic ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Aspirin ☐ Ibuprofen ☐ Latex ☐ Sulfa

☐ **AIDS**	☐ **Chest Pain**	☐ **Glaucoma**	☐ **Kidney Disease**	☐ **Scarlet Fever**
☐ **Alzheimer's Disease**	☐ **Cold Sores/Fever Blisters**	☐ **Hay Fever**	☐ **Kidney Problems**	☐ **Shingles**
☐ **Anaphylaxis**	☐ **Congenital Heart Disorder**	☐ **Heart Murmur**	☐ **Leukemia**	☐ **Sickle Cell Disease**
☐ **Anemia**	☐ **Convulsions**	☐ **Heart Pacemaker**	☐ **Liver Disease**	☐ **Sinus Trouble**
☐ **Angina**	☐ **Cortisone Medicine**	☐ **Heart Trouble**	☐ **Low Blood Pressure**	☐ **Spina Bifida**
☐ **Arthritis**	☐ **Diabetes**	☐ **Hemophilia**	☐ **Lung Disease**	☐ **Stroke**
☐ **Artificial Heart Valve**	☐ **Drug Addiction**	☐ **Hepatitis A**	☐ **Mitral Valve Prolapse**	☐ **Swelling of Limbs**
☐ **Artificial Joint**	☐ **Easily Winded Heart**	☐ **Hepatitis B or C**	☐ **Pain in Jaw Joints**	☐ **Thyroid Disease**
☐ **Asthma**	☐ **Emphysema**	☐ **Herpes**	☐ **Parathyroid Disease**	☐ **Tonsillitis**
☐ **Bleeding Problems**	☐ **Excessive Bleeding**	☐ **High Blood Pressure**	☐ **Pregnancy**	☐ **Tuberculosis**
☐ **Blood Disease**	☐ **Excessive Thirst**	☐ **HIV**	☐ **Psychiatric Treatment**	☐ **Tumors**
☐ **Blood Transfusion**	☐ **Fainting Spells/Dizziness**	☐ **Hives/Rash**	☐ **Radiation Treatments**	☐ **Ulcers**
☐ **Breathing Problem**	☐ **Frequent Cough**	☐ **Hypoglycemia**	☐ **Recent Weight Loss**	☐ **Venereal Disease**
☐ **Bruise Easily**	☐ **Frequent Diarrhea**	☐ **Intestinal Disease**	☐ **Renal Dialysis**	☐ **Yellow Jaundice**
☐ **Cancer**	☐ **Frequent Headaches**	☐ **Irregular Heartbeat**	☐ **Rheumatic Fever**	
☐ **Chemotherapy**	☐ ☐**Genital Herpes**	☐ **Joint Replacement**	☐ **Rheumatism**	

Tobacco Use? If so, what kind and how much? ______________________ Do you snore? _____________

Have you ever been hospitalized or had a major operation? ____

Reason for today's visit: _____________________________ Are you in pain? ____________________

Women, are you taking any oral contraceptives? Yes, or No (circle one) Pregnant or trying? ___________

Are you nursing? Yes, or No (circle one) Date of last cleaning and exam: _____________________

____ _______________________

Please Sign Here **Today's Date**

Operations Manager
Laura Gutierrez
11/21/2022

OFFICE FINANCIAL POLICY

In an effort to maintain treatment fees at a minimum while maintaining a high level of professional care, we have established the following financial policy for our office. Please feel free to discuss our fees with us at any time. Before any dental treatment has begun, the patient and/or responsible party will receive a consultation regarding treatment plan and cost.

We require payment in full for the portion, not covered by dental insurance, of dental services to be rendered. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required. We accept, cash, American Express, Visa, MasterCard, Discover and outside financing through credit applications to help assist with the cost of your dental treatment is available upon request. Personal checks are not accepted at Keene Family Dentistry.

By signing below, the patient agrees there is an understood “Assignment of Benefits” to Keene Family Dentistry (and affiliated companies). In some instances, the assignment of benefits is sometimes mistakenly overlooked by insurance companies and mailed to patients; in that scenario the patient is responsible for signing the check over to Keene Family Dentistry, and the balance will be the patients’ responsibility.

As courtesy to our patients with insurance, we will file your insurance claim, allowing you to pay only your deductible and/or **estimated** co-payment as services are rendered. Please remember that the contract is between you and your insurance company. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on the information provided to us. However, we have no way to guarantee the actual terms of your policy. Any dispute of coverage or the amount of reimbursement is between you and your insurance carrier. **By agreeing to this policy, you agree to all such conditions.**

At Keene Family Dentistry we schedule our appointments to provide each patient with our undivided attention. In order to accomplish this, we require 24**-hour confirmation** on all appointments. **Please be advised that you will be charged for cancellations with less than 24 hours’ notice** at the rate of $25.00 for examination/hygiene appointments and $75.00 for dental procedure appointments. Also note, the payment for services that are provided by patients for Keene Family Dentistry will be applied to patient balances. Should the patient change their mind for whatever reason during the treatment, the patient will still be responsible for full payment. Keene Family Dentistry guarantees cosmetic crowns and posterior crowns from breaking with a replacement crown for as long as the patient returns every six months for their regular cleaning, **for up to 1 year**.

We appreciate your confidence in choosing our practice. Please do not hesitate to inquire with a staff member should you have any questions regarding this policy.

By signing this you are stating that you have read, understood, and agree to the Office Financial Policy stated above.

______________________________ ______________________

Please Sign Here **Today’s Date**

ARBITRATION AGREEMENT

In the event any dispute arises in relation to any services provided by Keene Family Dentistry you agree to attempt and resolve the dispute with the Keene Family Dentistry Patient Experience Director for 60 days. You agree that there will be no assignment of any claim that you may have arising out of this agreement. You agree that the dispute will be submitted binding individual arbitration before the American Arbitration Association (AAA) under the Federal Arbitration Act subject to the laws of the State of Texas and that waive your right to sue in a court of law before a jury and are instead accepting the use of arbitration. It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by Keene Family Dentistry including any spouse or heirs of the patient at the time of the occurrence giving rise to any claim.

Informal Resolution; Mail a Notice of Dispute First. If you have a dispute and our patient care representatives cannot resolve it, you must send a notice of dispute by U.S. Mail to Keene Family Dentistry ATTN: Compliance, 428 S Old Betsy Rd, STE #C Keene, TX 76059. Tell us your name, address, how to contact you, what the problem is, and what you want. You will be notified in writing at the address provided in the new patient paperwork if we have a dispute with you. If any dispute is not resolved within 60 days, either party may initiate an arbitration if the dispute is unresolved.

Arbitration Procedure: The parties agree to conduct the arbitration with the American Arbitration Association the ("AAA") using one arbitrator under its Consumer Arbitration Rules. The parties agree that the Texas State Law shall govern with regard to any claims made in the arbitration, including any claims for medical malpractice. For more information, please see www.adr.org or call 1-800-778-7879. To initiate arbitration, you must submit an arbitration demand to the AAA and mail a copy to Keene Family Dentistry. In a dispute involving claims of $25,000 or less, you agree what any hearing will be telephonic unless the arbitrator finds good cause to conduct an in-person hearing instead. Any in-person hearing will take place in our principal place of business, Dallas, Texas.

Disputes Covered: Both you and Keene Family Dentistry understand and agree that any dispute as to medical/dental malpractice, including, but not limited to whether any medical/dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by a submission to arbitration as provided by federal law and not by a lawsuit or resort to court proceedings. Both parties to this agreement, by entering into it, are giving up their legal right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Both you and Keene Family Dentistry also understand and agree that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties to this agreement that the agreement binds all parties as to all claims that "arise out of" or "relate to" the treatment or services provided by Keene Family Dentistry . This agreement is intended to bind and cover Keene Family Dentistry all of Keene Family Dentistry independent contractors and employees, including those who now or in the future treat the patient while employed by, working or associated with Keene Family Dentistry Keene Family Dentistry . This agreement covers all claims for monetary damages, exceeding the jurisdictional limit of the small claims court against Keene Family Dentistry and/or Keene Family Dentistry associates, association, corporation, partnership, employees, agents, and estate must be arbitrated including, without limitation, claims for medical negligence, loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. If a claim falls within the jurisdiction of the small claims court in your country of residence, you and Keene Family Dentistry retain the right to seek relief in that court.

Arbitration Expenses: You and Keene Family Dentistry understand and agree that you each shall equally pay, at a rate of fifty percent each (%50), the fees, costs and expenses of the AAA arbitrator appointed to resolve any dispute covered by this Agreement. Both you and Keene Family Dentistry understand and further agree that each of you will also pay their own individual fees, costs and expenses for legal representation, experts and witnesses during the arbitration proceedings. With these exceptions, the arbitrator may award the same damages to you individually as a court could.

Joinder of Individual Claims into a Single Proceeding and Waiver: All individual claims based upon the same incident, transaction, or related circumstances between you and Keene Family Dentistry shall be arbitrated in one proceeding. A claim shall be waved and forever barred if: (1) On the date that notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statues of limitations, or (2) The claimant falls to pursue the arbitration claim in accordance with the procedures identified herein with reasonable diligence.

Prohibition Against Punitive Damages and Class Waiver: You and Keene Family Dentistry understand and agree that the arbitrator is not authorized to award punitive or other damages not measured by the prevailing party's actual damages. You and Keene Family Dentistry understand and agree that each may bring claims against the other only in an individual capacity and not as a plaintiff or class member in any purported class or unrepresentative action. Unless both you and Keene Family Dentistry agree, neither arbitrator or judge may consolidate more than one person's claims or otherwise preside over any form of a representative or class proceeding.

Continuation of Medical Services: Your failure to sign this agreement will not prevent you from receiving medical care.

Severability: If any part of this agreement is held to be invalid or enforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

By my signature below, I acknowledge that I am entitled to receive a copy of this agreement and may print a copy of this agreement after my electronic review and signature of the agreement or elect to be provided with a copy upon my arrival for services or treatment at Keene Family Dentistry .

______________________________ **Please Sign Here**

______________________________ **Today's Date**

Operations Manager
Laura Gutierrez
11/21/2022