Welcome!

Gentle Family Dentistry
Barbara Bowman-Hensley, DMD, MAGD, PA

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, we will be happy to help.

Patient Information

Patient Name:________________________ Social Security #:____________

Birth Date:______________ Age:__________ Gender: Male Female Other

Address:________________________ City, State, Zip____________

Full Time Student?______________ School Name____________

Employer______________ Occupation____________

Previous Dentist______________ Previous Dentist Phone ____________

Current Physician______________ Physician Phone ____________

Whom may we thank for referring you?________________________

Telephone & Email

Home Phone__________ Work Phone__________ Cell Phone__________

Email______________ Preferred mode of contact: Home Work Cell Email Text

May we remind you of appointments via email or text message?____________

In the event of an **emergency**, who should we contact?

Name______________ Relationship to patient____________

Home Phone______________ Work Phone____________

Responsible Party

Who is responsible for this account? Self Other - Relationship to patient?____________

Full Name________________________ Social Security #:____________

Marital status: Single Married Divorced Widowed

Birth Date______________ Male Female Other

Address______________ City, State, Zip____________

Employer______________ Occupation____________

Home Phone______________ Work Phone____________

Insurance Information

Dental Coverage Y or N

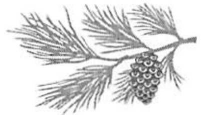
Insured's Name______________ Relationship to patient____________

Insured's Social Security #______________ Birth Date____________

Insurance Group #______________ Insurance Policy #____________

Insurance Co. Name______________ Insurance Co. Phone____________

6/16/2022 Revised



Gentle Family Dentistry
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MEDICAL HISTORY

Patient Name________________________ Nickname________________________ Age______

Name of Physician________________________ Date of most recent physical exam________________

Have you ever been told that you need antibiotics prior to dental treatment? ________________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1	hospitalization for illness or injury________	☐	☐
2	an allergic reaction to:	☐	☐
	☐ aspirin, ibuprofen, acetaminophen	☐	☐
	☐ penicillin	☐	☐
	☐ erythromycin	☐	☐
	☐ tetracycline	☐	☐
	☐ codeine	☐	☐
	☐ local anesthetic	☐	☐
	☐ fluoride	☐	☐
	☐ metals (gold, stainless steel, etc.)	☐	☐
	☐ latex	☐	☐
	☐ any other medications	☐	☐
3	heart problems	☐	☐
4	heart murmur	☐	☐
5	rheumatic fever	☐	☐
6	scarlet fever	☐	☐
7	high blood pressure	☐	☐
8	low blood pressure	☐	☐
9	stroke	☐	☐
10	artificial heart valve or artifical joint (circle one)	☐	☐
11	anemia or other blood disorder	☐	☐
12	prolonged bleeding from a slight cut	☐	☐
13	emphysema	☐	☐
14	tuberculosis	☐	☐
15	asthma	☐	☐
16	sinus trouble	☐	☐
17	kidney disease	☐	☐
18	liver disease	☐	☐
19	yellow jaundice	☐	☐
20	thyroid or parathyroid disease (circle one)	☐	☐
21	hormone deficiency	☐	☐
22	high cholesterol	☐	☐
23	diabetes	☐	☐
24	stomach or duodenal ulcer	☐	☐
25	digestive disorders________	☐	☐

		YES	NO
26	osteoporosis/osteopenia (circle one)	☐	☐
27	arthritis	☐	☐
28	glaucoma	☐	☐
29	contact lenses	☐	☐
30	head or neck injuries ________	☐	☐
31	epilepsy or convulsions	☐	☐
32	neurologic problems________	☐	☐
33	viral infections and cold sores________	☐	☐
34	any lumps or swelling in the mouth________	☐	☐
35	hives, skin rash, or hay fever (circle one)	☐	☐
36	venereal disease	☐	☐
37	hepatitis (state type)________	☐	☐
38	HIV or AIDS (circle one)	☐	☐
39	tumor or abnormal growth	☐	☐
40	radiation	☐	☐
41	chemotherapy	☐	☐
42	emotional problems	☐	☐
43	psychiatric care	☐	☐
44	antidepressant medications	☐	☐
45	alcohol or drug dependency (circle one)	☐	☐
46	autoimmune condition (Lupus, Sjogren's, etc.)	☐	☐

ARE YOU:

		YES	NO
46	presently being treated for another illness________	☐	☐
47	aware of a change in your general health	☐	☐
48	taking weight-management medication (ex. fen-phen)	☐	☐
49	taking dietary supplements	☐	☐
50	often exhausted or fatigued	☐	☐
51	subject to frequent headaches	☐	☐
52	a smoker or smoked previously (circle one)	☐	☐
53	considered a touchy person	☐	☐
54	often unhappy or depressed	☐	☐
55	FEMALE - using birth control	☐	☐
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 an additional sheet if you are taking more than 6 medications.

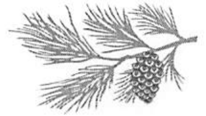
EASE ADVISE US IN THE FUTURE OF ANY MEDICAL HISTORY CHANGES OR NEW MEDICATIONS YOU MAY BE TAKIN

Patient's/Legal guardian's signature:________________________ Date:________________

Doctor's Signature:________________________ Date:________________

Revised 6/14/22

Gentle Family Dentistry
Barbara Bowman-Hensley, DMD, MAGD, PA



Patient name: ______________________

DENTAL HISTORY

Referred by ______________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Other
Previous dentist: ______________________ How long had you been a patient? ______________________
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than cleaning) ____/____/____
I routinely saw my dentist every ☐ 3mo ☐ 4mo ☐ 6mo ☐ 12mo ☐ 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 (on a scale of 1 [no] to 10 [very])? ____________	☐	☐
2	Have you had an unfavorable dental experience? ____________	☐	☐
3	Have you ever had complication from past dental treatment? ____________	☐	☐
4	Have you ever had trouble getting numb or had reactions to local anesthesia?	☐	☐
5	Did you ever have braces, orthodontic treatment, or have your bite adjusted? ____________	☐	☐
6	Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS			
7	Is there anything about the appearance of your teeth that you would like to change? ____________	☐	☐
8	Have you ever whitened your teeth?	☐	☐
9	Are you self conscious about your teeth?	☐	☐
10	Have you been disappointed with the appearance of previous dental work? ____________	☐	☐
BITE AND JAW JOINTS			
11	Do you have any problems chewing gum?	☐	☐
12	Do you have any problems chewing bagels or other hard foods?	☐	☐
13	Have your teeth changed in the last 5 years (become shorter, thinner, worn)?	☐	☐
14	Are your teeth crowding or developing spaces?	☐	☐
15	Do you have more than one bite, or do you clench to make your teeth fit together?	☐	☐
16	Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
17	Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	☐	☐
18	Do you have tension headaches or sore teeth?	☐	☐
19	Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE			
20	Have you had any cavities within the past three years?	☐	☐
21	Do you have a dry mouth?	☐	☐
22	Are any teeth sensitive to hot, cold, biting, or sweets? ____________	☐	☐
23	Have you ever had a toothache; cracked filling; broken, chipped, or cracked tooth?	☐	☐
24	Do you avoid brushing any part of your mouth? ____________	☐	☐
25	Do you feel or notice any holes (pitting) in your teeth?	☐	☐
GUM AND BONE			
26	Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
27	Have you ever experienced gum recession?	☐	☐
28	Does anyone in your familiy have a history of periodontal disease? ____________	☐	☐
29	Do your gums bleed when brushing, flossing, or eating?	☐	☐
30	Are your teeth becoming loose?	☐	☐
31	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
32	Have you experienced a burning sensation in your mouth?	☐	☐

Patient's/Legal Guardian's Signature: ______________________ Date: ____________

Doctor's Signature: ______________________ Date: ____________

Authorization for Release of Information – Compound Release

Name of Patient ____________________________________ Date of Birth ____________

Barbara Bowman-Hensley, DMD, MAGD, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Method to Receive Information

- ☐ Voice mail
- ☐ Other person(s) ______________________
- ☐ Text ______________________
- ☐ Other person(s) ______________________
- ☐ Email ______________________
- ☐ Other person(s) ______________________
- ☐ For email communications, I understand that that if email is not sent in an encrypted manner, there is a risk it could be accessed in appropriately. I still elect to receive email communication.

Description of information to be released
Check each that can be given to person/entity on the left in the same section.

- ☐ Results of lab tests/x-rays
- ☐ Premedication instructions
- ☐ Financial
- ☐ Treatment
- ☐ Appointment reminders
- ☐ Breach notifications
- ☐ Other: ______________________

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request, and this authorization will remain in effect until revoked by the patient.

Date ____________________

Patient Signature or Personal Representative ______________________________________
*Description of Personal Representative's Authority (Attach necessary documentation.)

Revised August 2013

Barbara Bowman-Hensley, DMD, MAGD, PA
Gentle Family Dentistry

Office Policy

Broken/Canceled Appointments: We ask that you diligently commit to all reserved appointment times as this can negatively affect your own oral health. It also can influence the practice by increasing the cost of operation for all of us and eliminating the opportunity for patients who need access to care. We have reserved special time for your dental care, and we do not overbook patients to allow you quality time with the doctor and our staff. We request at least two business days' notice for changing or canceling an appointment. Please be aware that a broken-appointment fee may be applied for significant and/or multiple cancellations to help offset the effects on the practice and the schedule. If you or members of your family have broken two appointments in a 6-month period or three in a 12-month period, we may be unable to schedule you or your family for further treatment.

Parents/Legal Guardians: A parent or legal guardian must complete, sign, and date a minor's (less than 18 years old) health history form. A parent or legal guardian must be in the waiting room at all times during a minor's treatment in case of a change of planned treatment or an emergency. Unless there are very unusual circumstances, we ask that parents or legal guardians remain in the waiting room during their child's treatment. **The responsible party accompanying the patient to the office is responsible for payment at the time services are rendered.** We ask that an adult always accompany younger children during restroom visits.

Visitors: Periodically COVID cases spike in our area, and we anticipate to see this continuing into the unforeseen future. To minimize the spread of disease and cross-contamination, it is imperative that friends and non-essential family members do not accompany the patient to the appointment. Should this be unavoidable, we ask that friends and non-essential family members remain in their car or fully masked in the lobby and do not accompany the patient into the treatment room.

Medication: If recommendations for treatment cannot be followed through within a reasonable time frame, we will refill antibiotics one time. **To better protect our patients, our practice, and our community, we do not prescribe opioid medications.**

Cellphone Usage: We request cellphones be turned off or silenced during your entire visit. If a call is absolutely necessary, we ask that you step outside to make/receive calls.

Smoking: This is a smoke-free facility; please refrain from smoking inside and immediately adjacent to our building.

Food/Drink: No food or drinks are to be brought into or consumed in our lobby or treatment areas at any time.

Pre-payment is required to schedule any restorative work or treatment that includes outside lab work unless you are using an HSA card, FSA card, or CareCredit.

This office follows the guidelines for x-ray protocol recommended by the North Carolina Dental Board of Examiners and the American Dental Association. To provide you with the best and most appropriate care, we must follow the standard of care by having current diagnostic x-rays of your mouth and surrounding structures.

New Patients

Adults

- Full-mouth series or a panoramic x-ray if you do not have an acceptable one from another source three to five years old
- Bitewing x-rays if you do not have acceptable ones from another source up to one year old
- Individual periapical x-ray(s) to examine the following:
    - Existing crown(s) and/or bridge(s)
    - Discolored teeth
    - Teeth with prior root canals

- Any tooth with a four-surface or larger filling(s) and/or pin-related filling(s)
    - Any area in the mouth where periodontal pocket depth exceeds 4mm
    - Some of these indications for periapical x-ray(s) may become apparent after bitewings are taken, and the patient's clinical need may dictate a different protocol.

Children/Teenagers

- Bitewings and panoramic or occlusal films or as needed for selected cases based on clinical need

Existing Patients

- The protocol for x-rays is determined by the individual patient's need and Dr. Bowman-Hensley's professional judgment. Bitewings for adults are recommended by the ADA and the North Carolina Dental Board of Examiners yearly and are absolutely required every two years. Full-mouth series or a panoramic x-ray will be taken every three to five years. Individual periapical x-ray(s) will be taken for symptomatic teeth and for routine evaluation of older restorations and teeth with a history of trauma.

Without the necessary x-rays to diagnose and treat patients with a standard of care acceptable to this community and within the existing governing guidelines, Dr. Bowman-Hensley cannot legally perform dental services. Patients who delay x-rays beyond the minimum requirement and/or standard of care will be asked to find dental services at another office. We will be glad to refer your records to the dentist of your choice if you are unable to comply with the ADA's and this office's x-ray policy.

Treatment Alternatives/Referrals: Dr. Bowman-Hensley may provide you with treatment alternatives/referrals options or other health-related services depending on each individual's need.

Appointment Reminders: We will contact you as a reminder about upcoming appointments or treatment through multiple means of communication. You may opt out of these reminders at any time.

Patient Signature (Parent/Guardian if minor): ________________________________ **Date:** _____________

Revised June 1, 2022

Financial Policy

Payment Policy: Customary payment is required on the day of services or in the case of restorative and lab-related appointments. We do not routinely invoice for balances of services after the fact. If the party responsible for payment cannot be present at the appointment, arrangements must be made well before the appointment. For your convenience we accept cash, MasterCard, VISA, AMEX, Discover, and only for established patients checks and CareCredit. CareCredit is a third-party payment plan consisting of a separate line of credit for dental purposes only with no interest if paid within the agreed-upon time. More information and applications for CareCredit are available at *carecredit.com*.

Implant Crowns: To schedule final impressions for any implant crown, **full prepayment is required**. Implant parts for the impression will be coordinated by the treating doctor and staff prior to scheduling. **Should you cancel your final impression appointment with less than two business days' notice, $150 of the full prepayment will not be refunded.**

Administrative Fees: It is a normal part of our practice to do many extra services for our patients, and we are happy to provide this special customer service. However, in situations where extraordinary time is required to coordinate insurance, manage your dental treatment, transfer your x-rays/records, or complete referrals, an administrative fee may be applied at Dr. Bowman-Hensley's discretion.

Broken Appointments/Cancelations: If you must cancel or break an appointment with less than two business days' notice (not including holidays), it is considered a broken appointment. **A fee of $75 for preventative appointments and $150 for doctor's-time appointments may be applied to your account for any broken or canceled appointments.** Of course, accidents, illness, and certain circumstances are taken into consideration. If there are any credits or prepayments on your account, they may be applied to past or current breaks or cancellations. Any fees owed to the practice will be applied prior issuing any necessary refund checks. If a refund is necessary, it will be issued only by check as soon as Dr. Bowman-Hensley is able to do so, regardless of your initial form of payment.

Treatment Plans: When dental work is recommended, Dr. Bowman-Hensley and her staff will provide you a detailed treatment plan and our best estimate on what your cost will be before any work is begun. We will be happy to answer any questions you may have about your proposed treatment. All fees on any treatment plan are subject to change over time to accommodate increased material and lab fees. We can only honor the fees quoted for the services on your treatment plan for 90 days from the date of signing. If you delay treatment and it becomes more complex, the fees will be changed to reflect this. If more than six months has passed since your treatment plan was created, a re-evaluation of your dental condition may be necessary. If treatment options change for any reason before or once the treatment has begun, we will obtain your consent before continuing with treatment and will provide you with a new estimated fee.

Dental Insurance Subscribers: Dental insurance policies have evolved greatly over the past few decades. Today's insurance policies are best perceived as a coupon toward your treatment as they no longer provide any comprehensive reimbursement like medical insurance. Insurance plans are a contract between you, your employer (if applicable), and the insurance company. The dollar amount set for each procedure is set by the individual's contract and varies greatly. In years past, we could reliably estimate copayments and reimbursements, but we can no longer do that as easily. We can never guarantee what any particular plan will pay toward your treatment. Please be aware that, depending on your individual policy, insurance companies will elect not to cover certain aspects of procedures routinely performed.
Insurance companies also have annual plan limitations, setting cost parameters within which they will pay. These limitations help employers provide benefits to more people; however, these limitations may severely restrict the amount of work you are able to receive in a plan year. Once insurance has paid out according to your plan limitations, payment in full is required for all dental services for the remainder of your plan year. Most benefits renew on January 1st, but these renewal dates may vary. It is impossible for our staff to know every nuance of your individual policy. Therefore, it is your responsibility as the policy holder to be aware of any limitations or waiting periods you may have.
As a courtesy for established patients, we do file most insurances. Patients with **AARP**; **Medicare-backed, Exchange**, or **Federal policies**; or **Blue Cross Blue Shield** will be responsible for paying their bill in full at the time of service and will get reimbursed directly from their insurance carrier.
As mentioned above, it is a rare policy that does not require at least a small copay for all services. After your copay (if applicable), we will accept the remaining payment directly from the insurance company. **Any remainder not paid by insurance is your full responsibility.** For restorative services or work using outside lab services, **we require your estimated portion in full to schedule treatment**. Please make sure we have all necessary information correct including your full legal name, policy number, your employer (if applicable), birthday, social security number, address, and phone number well before your appointment to avoid any delay in receiving reimbursement.

1. We are not a contracted provider with any insurance group or network **except Delta Dental Premier** and **Delta Dental PPO + Premier**.
2. We do not file secondary insurance but will be happy to provide you with procedure codes that you may file on your own.
3. We will request full prepayment on services not explicitly listed as covered by your insurance company. If you receive benefits for any given procedure already paid for, the benefits will be directed to you.
4. Any balance remaining after insurance reimbursement is your responsibility, regardless of the reason or any previous payment you made toward treatment. Balances must be paid in full within 30 days of the date of service.

By signing below, I authorize Barbara Bowman-Hensley, DMD to consent to use and disclosure to any third-party payer any of my protected information necessary for payment of any charged related to my dental treatment. I understand that I am responsible for all the costs of dental treatment. I authorize payment directly to Barbara Bowman-Hensley, DMD of insurance benefits and other third-party payment for dental treatment and related charges otherwise payable to me.

Patient Signature (Parent/Guardian if minor) ____________________ Date ____________ *Revised June 1, 2022*

Barbara Bowman-Hensley, MAGD, DMD, PA
Gentle Family Dentistry

Notice of Privacy Practices

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside our facility who are involved in your care.

We may use or disclose your protected health information (PHI) in the following situations UNLESS you object.

- We may share your information with friends or family members or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post-procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person responsible for your care of your location, general condition, or death.
- We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization: marketing, disclosures for any purposes which require the sale of your information. All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative. Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

You have certain rights related to your PHI. All requests to exercise your rights must be made in writing. Patients can obtain these request forms from the office, and the requests should be directed to the Privacy Officer.

- **You have the right to see and obtain a copy of your PHI.** This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.
- **You have the right to request a restriction of your PHI.** You may request for this practice not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request, we will honor the restriction request unless the information is needed to provide emergency treatment.
- **There is one exception.** We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.
- **You have the right to request for us to communicate in different ways or in different locations.** We will agree to reasonable requests. We may also request an alternative address or other method of contact such as mailing information to a post-office box. We will not ask for an explanation from you about the request.
- **You may have the right to request an amendment to your health information.** You may request an amendment of your health information if you feel the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have the opportunity to disagree.
- **You have the right to a list of people or organizations who have received your health information from us.** This right applies to disclosures for purposes other than treatment, payment, or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous 6 years or a shorter time frame. If you request more than one list within a 12-month period, you may be charged a reasonable fee.
- **You have the right to obtain a paper copy of this notice from us upon request.** We will provide you a copy

of this Notice the first day we treat you at our facility. In an emergency situation, we will give you this Notice as soon as possible.

- **You have the right to receive notification of any breach of your PHI.**

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices, you can contact Dr. Barbara Bowman-Hensley, DMD, MAGD, PA at the following address:

1674 Tunnel Road
Asheville, NC 28805
(828) 299-8824

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. IF you file a complaint, we will not retaliate against you.

This Notice was published and becomes effective on April 14, 2003.

Patient Signature (Parent/Guardian if minor): ______________________________ Date: ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Barbara Bowman-Hensley, DMD, MAGD, PA

* You may refuse to sign this acknowledgement *

I have received a copy of this office's Notice of Privacy Practices.

____

Please print name

____

Signature

____

Date

____

For Office Use Only

____

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

____

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