BLOOMING DENTAL

Patient Information

First Name: _____MI: ____ Last Name: _____
Email: _____ Work Phone: _____ Cell Phone: _____
DOB: _____ Gender: □ Male □ Female Social Security #: _____
Address: _____ City: _____ State: _____ Zip:_____
Name of Physician: _____ Physician Phone: _____
In case of Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about our office: _____

Patient Health History

Do you have a history of (Check if applicable):

AIDS/HIV Positive (에이즈) □	Excessive Bleeding (과다출혈) □	Jaundice (황달) □	Respiratory Problems/Disorder (호흡기질환) □
Alcoholism (알콜중독) □	Epilepsy (뇌전증) □	Kidney Disease (간질환) □	Rheumatic Fever (류마티스열) □
Allergies (알레르기) □	Glaucoma (녹내장) □	Kidney Dialysis (신장투석) □	Rheumatism (류마티스) □
Anemia (빈혈증) □	Hay Fever (고초열) □	Latex Sensitivity (유액감도) □	Scarlet Fever (섬홉열) □
Arthritis (관절염) □	Head Injuries (두부손상) □	Lupus (루푸스) □	Seizures/Fainting spells (간질) □
Asthma (천식) □	Hearing Impaired (난청) □	Low Blood Pressure (저혈압) □	Sinus Problems (부비강염) □
Blood Disease (혈액질환) □	Heart Disease (심장질환) □	Malignancies (악성종양) □	Stomach Ulcers (위제양) □
Bone Disease (뼈질환) □	Heart Valve, Murmur (심잡음) □	Mitral Valve Prolapse (승모판막탈출증) □	Stroke (뇌졸증) □
Cancer (암) □	Hepatitis/Liver Disease (간염) Type(s) _____ □	Neck & Back Problems (허리통증) □	Thyroid Disease (갑상선) □
Chemical Dependency (약물의존) □	Hepatitis Carrier □	Nervous Problem/Disorders (신경쇠약) □	Tuberculosis (결핵) □
Chest Pain (가슴통증) □	High Blood Pressure (고혈압) □	Pacemaker (심박조율기) □	Tumor or growths (종양) □
Circulatory Problems (순환기장애) □	Hip or Joint Replacement (전고관전 대치술) □	Prosthetic Joints (보철관절) □	Ulcers (궤양) □
Convulsions/Seizures (경련) □	HPV (유두종 바이러스) □	Psychiatric Care (정신의학) □	Venereal Diseases (성병) □
Diabetes (당뇨) □		Radiation Treatment (방사선치료) □	

Medical Questions:

List any medications you are taking including nonprescription drugs:

_____

_____

Do you have any disease/problem you think we should know about?

_____

_____

Are you allergic to any medications? If yes, please list below:

_____

_____

Date of last medical exam: _____

Have you had an allergic reaction to Bananas? Yes ☐ No ☐

Do you smoke or chew tobacco? Yes ☐ No ☐

Have you had Heart Surgery? Yes ☐ No ☐

For Women Only:

Are you taking birth control pills? Yes ☐ No ☐

Are you Pregnant? Yes ☐ No ☐ Expected delivery date: _____

Are you nursing/breastfeeding? Yes ☐ No ☐

Is there a possibility of pregnancy? Yes ☐ No ☐

Dental History Information:

Date of last dental visit: _____

Name of your previous dentist _____

Reason for today's visit? _____

Do you have problems with bad breath? Yes ☐ No ☐

Do you snore? Yes ☐ No ☐

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? Yes ☐ No ☐

Have you ever had an oral cancer screening? Yes ☐ No ☐

Have you ever used an electric toothbrush? Yes ☐ No ☐

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold or pressure?	Yes ☐ No ☐
Do your gums bleed when you brush?	Yes ☐ No ☐
Have you or a family member been treated for periodontal disease?	Yes ☐ No ☐
Have you ever had complications from an extraction?	Yes ☐ No ☐
Have you ever had a popping or clicking near your ear when you chew?	Yes ☐ No ☐
Are you prone to frequent headaches?	Yes ☐ No ☐
Do you grind or clench your teeth?	Yes ☐ No ☐
Do you have sores, blisters or swelling on your gums, lips, or cheeks?	Yes ☐ No ☐
Have you ever had orthodontic treatment?	Yes ☐ No ☐

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any eros that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or s-rays, as may be deemed necessary by the doctor.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

BLOOMING DENTAL

Patient Arrangement Form

Name of Patient:_____

Payment Agreement:

I agree that I am responsible for all services rendered to the patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and copays at the time of service (if I have dual insurance coverage, my copay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

Responsible Party:

Full Name: _____ DOB: _____ SSN#: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Employer Name: _____

Insurance Information:

Primary Insurance:
Insurance Name: _____ Address: _____ Phone Number: _____
Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

Secondary Insurance:
Insurance Name: _____ Address: _____ Phone Number: _____
Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ **Date:** _____

BLOOMING DENTAL

Notice of Privacy Practices

Blooming Dental respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of health information that we create and obtain in providing our care and service to you. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operation. State law requires us to get your authorization to disclose this information for payment purposes.

The health and billing records we create and store are the property of Blooming Dental. The protected health information in it however generally belongs to you. For help with your rights during normal business hours, please contact the office manager.

We are required to keep your protected health information private, give you this notice, and follow the terms of this notice. We have the right to change our practices regarding the protected health information we maintain. If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact the office manager.

Notice of Privacy Practices: Acknowledgement

We keep a record of the dental care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. You may contact the office manager to see your record or get more information.

By my signature below I acknowledge receipt of the notice of privacy practices.

Signature of Patient or Legal Guardian: _____ Date: _____

BLOOMING DENTAL

Blooming Dental Office Policy

Thank you for choosing Blooming Dental as your dental provider. We are committed to providing the best dental treatment. The following is a statement of our office policy, which we require you to read and sign prior to any treatment.

Full Payment is due at the time of service

Payment is expected when the services are performed unless prior financial arrangements have been made.

Cancellation and missed appointments

Unless canceled at least 24 hours in advance there will be a $60 charge for missed appointments. That is the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments or rescheduling in advance.

Regarding Insurance

We will gladly process the insurance claims for you. However, most insurance companies do not fully cover dental charges. Therefore your “estimated patient portion” and deductible are due at the time of your treatment.

Dual Insurance

Due to the extended amount of time that it takes to process claims for dual insurance we are asking that the patient pay what the secondary insurance would be estimated to cover out of pocket at the time of treatment. This is to better enable our office to cover material and lab fees that may come up while working on your case. After receiving payment from the primary insurance we will give you the secondary insurance company the permission to release their payment to the patient rather than sending it to the provider.

Usual and Customary Fees

This office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Minor Patients

Non-emergency treatment will be denied for unaccompanied minors. The approval of parents or a legal guardian is required before any treatment can be started. The adult accompanying the minor is responsible for full payment.

Delinquent Account

For the delinquent accounts (more than 90 days past due), the interest in the amount of 1% per month will be charged and provided by the law.

Thank you for understanding our office policy. Please let us know if you have questions or concerns.
I have read the office policy. I understand and agree to this policy.

Signature of Patient or Guardian: _____ **Date:** _____