BALSAM
DENTAL

Welcome to our office!

Patient Name: _____

Preferred Name: _____ Date of Birth: _____

Social Security #: _____

Full Mailing Address: _____

Best Contact Number: _____

Email Address: _____

Emergency Contact Name/Number: _____

How did you hear about our office? _____

Responsible Party Information (If other than patient):

Name: _____ Date of Birth: _____

Full Mailing Address: _____

Dental Insurance Coverage, please circle one: **YES** or **NO** – if yes please provide card at check in

Dental Ins Co: _____ Member ID#: _____

Policy Holder Name and Date of Birth, if other than self:

_____ _____

Privacy Practice Agreement

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
In regard to Privacy, I understand that Balsam Dental staff may use or disclose personal health information for the purposes of carrying out treatment, specialty referrals, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that any request will be considered on a case by cases basis, but Balsam Dental does not have to agree to requests for restrictions.

_____ _____
Signature of Patient /Responsible Party Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Balsam Dental

HIPAA FORM

Name of Patient_____Date of Birth _____

Balsam Dental is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
• Check if we can leave a Voice Mail regarding:	☐ Appointment reminders ☐ Financial Info ☐ Treatment
• List any other person (s) than yourself that we can speak with regarding:	☐ Financial Info ☐ Appointment reminders ☐ Treatment
• Check if we can Email the provided email address regarding: *	☐ Financial ☐ Treatment ☐ Appointment reminders
• Check if we can Text the provided cell number regarding: *	☐ Appointment reminders ☐ Financial Info
Please choose answer: • Any photo taken by staff for chart only (Example: pre/post procedure) – YES OR NO • May be posted in office – YES OR NO • May be posted on website – YES OR NO	*For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- 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.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Balsam Dental

Thank you for choosing our office for your dental needs. Our goal is to provide modern dental treatment in a relaxed, caring environment. Dentistry is a partnership between the staff and patient. The following polices help create a positive experience for each of us!

Financial and Cancellation Policies

Payment

- Payment is expected at the time of service.
- Payment for major treatment (crowns, implants, multiple resins/extractions, root canal etc.) is due when scheduling.
- Cash, personal check, Visa, MasterCard, American Express and Discover are accepted.
- There is a $25 fee for returned checks.
- We accept Care Credit, which offers many interest-free options for monthly payments.
- A $25 monthly billing fee is applied to all balances over 60 days.

Insurance

- We are not in network with any insurance, however, as a courtesy to our patients, we will be glad to file your dental insurance. Ultimately, it is the **patient's responsibility** to keep up with all their insurance benefits and any changes that may take place.
- We **cannot** and **do not** guarantee payments from insurance companies. The insurance company determines all benefits.
- Patient's deductible and estimated portion of fees are **due at time of scheduling the appointment**. All unpaid balances are the responsibility of the patient **regardless** of insurance reimbursement and are due within 30 days of treatment.
- Your insurance is a contract between you and the insurance company.

Cancellations

- A $50 fee will be charged for "no-shows" of confirmed appointments.
- We ask that you provide 24 hour notice if you are unable to keep your appointment.
- After three broken appointments, no further appointments will be scheduled.
- Appointments that are not confirmed at least 24 hours prior may be cancelled due to no confirmation.
- **Patient's arriving 10 or more minutes late may be rescheduled.**

Minors

- Parent or guardian must be present for the duration of a minor's appointment.
- The person presenting the patient to our office is responsible for payment of services rendered.

I agree that I am fully responsible for the total payment of all procedures performed in this office. I understand that all services are due to be paid in full within sixty (60) days of the date of service, regardless of whether or not my insurance benefits have been received. Accounts over 60 days past due will be assessed a $25.00 billing fee. Accounts over 90 days will be turned over to our collection agency.

Signature of Patient/Responsible Party Date

_____ _____