



## 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 <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|                                                                              |                                                                              |                                                                          | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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.                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>Check if we can leave a Voice Mail regarding:</li></ul>                                                                                                                                                               | <input type="checkbox"/> Appointment reminders<br><input type="checkbox"/> Financial Info<br><input type="checkbox"/> Treatment                                                                                                                    |
| <ul style="list-style-type: none"><li>List any other person (s) than yourself that we can speak with regarding:</li></ul>                                                                                                                                   | <input type="checkbox"/> Financial Info<br><input type="checkbox"/> Appointment reminders<br><input type="checkbox"/> Treatment                                                                                                                    |
| <ul style="list-style-type: none"><li>Check if we can Email the provided email address regarding: *</li></ul>                                                                                                                                               | <input type="checkbox"/> Financial<br><input type="checkbox"/> Treatment<br><input type="checkbox"/> Appointment reminders                                                                                                                         |
| <ul style="list-style-type: none"><li>Check if we can Text the provided cell number regarding: *</li></ul>                                                                                                                                                  | <input type="checkbox"/> Appointment reminders<br><input type="checkbox"/> Financial Info                                                                                                                                                          |
| <p>Please choose answer:</p> <ul style="list-style-type: none"><li>Any photo taken by staff for chart only<br/>(Example: pre/post procedure) – YES OR NO</li><li>May be posted in office – YES OR NO</li><li>May be posted on website – YES OR NO</li></ul> | <p>*For <b>email and/or text communication</b> 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.</p> |

### 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.

\_\_\_\_\_  
Signature of Patient or Personal Representative

Date \_\_\_\_\_

## Balsam Dental Office Policies

*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 patients. The following policies help create a positive experience for each of us!*

### Payment

- Payment is expected at the time of service.
- 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.
- 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 90 days will be turned over to our collection agency.**

### 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 \$60 fee per hour 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.
- **Patients arriving 15 or more minutes late may be rescheduled.**

### Minors

- Parent/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.

### Radiographs

- I understand that Balsam Dental follows ADA guidelines and requires bitewing images to be completed yearly or at least every 18 months for proper diagnoses. Also, a full mouth panoramic image to be completed every 3 years or at least every 5 years to rule out pathology of the head and neck. I have the right to refuse images however I understand this is standard of care and I may need to cancel my appointment.

Signature of Patient/Responsible Party

Date

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