MEDICAL HISTORY

Patient Name_____ Preferred Name _____

Birthdate_____ Age_____ (Circle) Male Female

SS#_____ Responsible Party Name_____

Child's Address_____

City, State, Zip_____ Phone_____

School_____ Referred By_____

Patient's Pediatrician_____ Phone_____

MEDICAL HISTORY
Previous hospitalizations/surgeries/serious illnesses?_____
Is Patient currently taking any medications? (If Yes, List)_____
_____
Does Patient have a history of allergies to drugs or medications (Penicillin, Novocaine, etc.)? (If Yes, List)
_____
Does Patient have history of allergies to any other substances (latex, environmental, etc.)? (If Yes, List)
_____
Does Patient have, or ever had, any of the following? (Circle)

Asthma?	Yes	No	Stomach, liver or kidney problems?	Yes	No
Cancer?	Yes	No	Handicaps/Disabilities?	Yes	No
Hepatitis?	Yes	No	Abnormal Bleeding?	Yes	No
HIV/AIDS?	Yes	No	Diabetes?	Yes	No
Hemophilia?	Yes	No	Rheumatic Fever?	Yes	No
Heart Murmur?	Yes	No	Congenital Heart Defect?	Yes	No
Tuberculosis?	Yes	No	Convulsions/Epilepsy?	Yes	No
Pregnancy?	Yes	No			

Please list any other medical problems the Patient has:_____
_____

DENTAL HISTORY
Is this Patient's first visit to a dentist? (Circle) Yes No
If not, how long since last visit?_____
Previous Dentist:_____ Phone_____
Has Patient had difficulty with previous dental / medical visits?_____
How often does Patient brush?_____
How often does Patient floss?_____
What does Patient drink most often?_____

Does patient snore? (Circle)		Yes	No
Are tonsils and adenoids out? (Circle)		Yes	No
Breathe through mouth often? (Circle)		Yes	No
Does Patient…	Suck thumb/finger/pacifier?	Yes	No
	Suck/bite lip?	Yes	No
	Bite/chew nails?	Yes	No
	Chew hard objects (i.e. pencil)?	Yes	No
	Grind teeth?	Yes	No
	Clench jaws?	Yes	No

Have there been any injuries to teeth – falls, blows, chips, etc.?_____

Reason for today's visit:_____

Authorization and Release
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 the Patient's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform necessary dental services my child may need. It is my responsibility to inform the dental office of any changes in medical status. I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners.

_____ _____
Signature of Parent/Guardian Date

Dr. Michael D. Blen, DDS, P.C.

Privacy Policy

We are committed to protecting your personal information. Medical history, dental history, account information and services rendered are just some of the items covered in our patient records. We need these records to provide for your child's care and to comply with certain legal requirements. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. This Notice is permanently posted at our front desk and a copy will be furnished for your records upon request. You will be notified upon your next visit if this Notice changes and a copy will be presented for your review.

I have read and understand my rights to review the policy. I also understand that, by signing this Consent form, I am giving my consent to this office's use and disclosure of my protected health information.

_____	_____	_____
PATIENT(S)	Signature of Responsible Party	Date

Dr. Michael D. Blen, DDS, P.C.
Financial Policy

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards.
2. For new patient emergency visits we require payment in full at the time of the appointment.
3. As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file the insurance for you.
4. Our office will file your insurance claim a maximum of **two times** per appointment.
5. **If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.** We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.
6. You must provide the office with accurate dental insurance information with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.
7. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
8. The office cannot carry balances longer than 60 days, regardless if the insurance payment is still pending. A $5.00 re-billing charge will be added to your account if it is not paid within 60 days, regardless of the balance amount.
9. After 60 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will employ a collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees. Once an account is delinquent, we will no longer file your insurance and you will need to pay for each visit in full at the time of treatment.
10. There will be a $30.00 service charge for all returned checks.
11. **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.**

AUTHORIZATION

I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

_____	_____	_____
PATIENT(S)	Signature of Responsible Party	Date

ACCOUNT INFORMATION
FAMILY REGISTRATION FORM

PATIENT(S)

Child #1: Name_____

(Circle) Male or Female Date of Birth _____

Child #2: Name_____

(Circle) Male or Female Date of Birth _____

Child #3: Name_____

(Circle) Male or Female Date of Birth _____

Child #4: Name_____

(Circle) Male or Female Date of Birth _____

□ **MOTHER or** □ Stepmother □ Guardian

Name_____ Home Ph_____

Work Ph_____ Ext_____ Cell Ph_____

Address_____

City, State, Zip_____

DOB:_____ SS#_____DL#_____

Employer:_____ Occupation:_____

Marital Status (Circle) Single Married Divorced Widowed Separated

□ **FATHER or** □ Stepfather □ Guardian

Name_____ Home Ph_____

Work Ph_____ Ext_____ Cell Ph_____

Address_____

City, State, Zip_____

DOB:_____ SS#_____DL#_____

Employer:_____ Occupation:_____

Marital Status (Circle) Single Married Divorced Widowed Separated

Contact E-mail:_____

Family Dentist_____ Physician_____

PLEASE COMPLETE PAGE 2

DENTAL INSURANCE

I have secondary insurance (please circle): YES NO

Please provide a copy of your insurance card(s) for verification and filing of claims.

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name_____ Relationship to Patient(s)_____

Home Ph:_____ Cell_____ Work_____

Best Time to Call_____ Days_____

EMERGENCY INFORMATION, if other than parent/guardian

Who can we contact in case of emergency?_____

Relationship to Patient(s)_____ Home Ph_____

Cell Ph_____ Work Ph_____

Address_____

REFERRAL INFORMATION

How did you learn about our office? (Circle, if applicable) School Visit Yellow Pages

Sign Other (please list)_____

CONSENT

It is necessary that signed permission be obtained from the parent or guardian before any necessary dental services can be performed by staff of Dr. Michael Blen, DDS. Authorization is hereby granted as such. Furthermore, I agree to be financially responsible for payment of patient(s)' account.

Signed_____ Date_____

Relationship_____