General Information

Patient Name_____ Date of Birth _____

If Minor Parent/Guardian _____

College Student? **Y** **N** {Please circle one}

Address_____City_____

State _____Zip _____ Home Phone_____ Work Phone_____ Cell Phone_____

Email_____ {Please indicate the best number to reach you and if we can use email correspondence}.

Whom May We Thank For Referring You to Our Office_____

Responsible Party Information

Name/Subscriber of Insurance_____Employer_____

Address {if different than above} _____Cell #_____

Social Security #_____ Marital Status_____ Birth Date_____

Relationship to patient_____ If Minor-Whom do we bill? _____

INSURANCE

Insurance Co. _____Insurance Phone #_____

Member ID_____ Group/Plan ID_____

Insurance phone #_____

Secondary Plan? **Y** **N** {Please circle one}

Insurance Subscriber_____Employer_____

Insurance Company_____ Member ID_____

Group ID_____ Phone #_____

Medical and Dental History

Date_____

Patient Name_____

Birthdate_____

Name of Parent/Spouse_____

Last Physical_____ Are you under the care of a physician currently? _____

If yes, please describe your condition_____

_____

Last Dental Exam/Cleaning _____Last Dental X-rays_____

Do you have difficulty getting numb for dental procedures ?_____

History of any gum disease/ infections ?_____

Are you allergic to Penicillin or any other medications? _____Are you allergic to Latex ?_____

What medications are you currently taking?_____

_____

Do you smoke ?_____ If yes, how often?_____ Have you ever been a smoker or used tobacco?_____

Have you ever been diagnosed with and of the following? Please circle:

Allergies_____

Heart Condition/Treatment	Rheumatic Fever	High/Low Blood Pressure	Diabetes	Seizures/Fainting
Lung Trouble	Asthma/Emphysema	Tuberculosis	Contagious Disease	HIV/AIDS
Kidney Problems	Osteoporosis	Bleeding Problems	Hemophilia	Anemia
Infectious Hepatitis	Liver Disease	Thyroid Problems	Glaucoma	TMJ Problem
Joint Replacement	Reflux/GERD	Other_____		

Please Describe _____

_____

I hereby certify that I have answered the above questions correctly and accurately. I authorize release of medical information pertinent to my care.

Patient/Guardian Signature_____Date_____

Date_____ Dr. Signature_____

Matthew P. Bleichen Dentistry

Office Policies

We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Before restorative treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what fees to anticipate, and allow you time to make the necessary financial arrangements. Payment plans and financial arrangements are available for comprehensive dental treatment. Please ask us about financing options we offer.

INSURANCE

Insurance benefits are determined by your employer. Your insurance policy is a contract between you and your insurance company. Knowledge of your insurance coverage and benefits is your responsibility. Insurance is not a guarantee of payment and it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if we are given all pertinent information for your insurance and employer. You will be expected to pay for services rendered if we are unable to verify your insurance information before treatment. We do not guarantee any verbal estimates given of insurance payments or copay amounts. Please note: Our office is not "in-network" with most insurance carriers. As long as you may choose who you see for your dental care, we can assist you in filing claims. If your insurance only pays benefits to the subscriber {you}, we may require you to pay for your visit at time of service and wait for direct reimbursement.

PRE-ESTIMATES FOR TREATMENT

For dental restorative and therapy treatments, we can file a pre-determination for you to give you an estimate of your coverage and out of pocket costs. Your insurance does not guarantee the amount shown for insurance payment and your copays, and neither can we guarantee any payment amounts. If we send a Pre-determination for you, it usually takes approximately 3 weeks to get a response. If there is a delay in your insurance responding, and you want to proceed with your treatment without it, we cannot be held liable for any unexpected balance you have after insurance has settled.

PARENTS

"Separated or divorced parents and guardians of minors, who are responsible for one half of the cost of a child's/children's dental care": The parent/guardian who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold a credit/debit number from the other parent/guardian on file.

EMERGENCY NEW PATIENTS

For new patient's emergency visits, we will require payment in full for the initial appointment. We may still be able to file a claim for you to be reimbursed. For future visits, we will collect the estimated copays due for services rendered according to your insurance.

LATE CANCELLED/BROKEN APPOINTMENTS

Appointments are times specially reserved for you.

Our office understands we all have busy lives and schedules can change. However, we strive to accommodate all our patients schedules, and request at least 24 hours of notice to change your appointment. If your appointment is on a Monday, please try to contact us on the Thursday prior.

In the event of an unforeseen emergency or illness, we will gladly change your appointment for you with no penalty. However, if you are continuously cancelling or changing your appointment, we reserve the right to determine a "Broken Appointment" fee at our discretion based on the type of appointment you had scheduled. {Not to exceed $175.00}.

BILLING

We will provide you with a statement of your balance after your insurance has settled. Remittance of your balance is due by the stated due date unless prior arrangements have been discussed. If you are unable to pay your balance in full upon receipt of your bill, simply give us a call and we will be happy to work out a plan that is comfortable for all. If you have not made a payment by the second statement sent, we may contact you by phone or email to arrange settlement of your bill.

Signature of
Patient/Guardian_____