Dr. Steven Hein & Dr. Matt Nelson

Welcome to our Practice!

Please help us by providing us with the following confidential information.

PATIENT INFORMATION: **(use black ink)**

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth _____

Prefer to be called: _____ Street Address: _____ City, State, Zip: _____

E-mail address _____ Marital Status: (circle one) Single, Married, Separated, Divorced, Widowed

Cell Phone: _____Work Phone: _____ Home Phone: _____

Sex : _____ M _____ F SS#: _____ Driver's License:_____

Occupation: _____ Employer: _____ Address: City, State, Zip _____

Emergency Contact Name: _____ Phone #: _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____ City, State, Zip: _____

Spouse's Employer: _____ Address: City, State, Zip: _____

How did you hear about our office? Please check: _____ Internet Search ____ Patient referral ____Website _____Yellow Pages Other _____

If you were referred whom may we thank for their trust in us? _____

DENTAL INSURANCE INFORMATION:

Primary Insurance Company:_____ Insurance Co. Phone #: _____

Insurance Co. Address: _____ City: _____ State/Zip: _____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____

Member ID #:_____ Group # or Policy #: _____

Employer: _____

Is patient covered by another dental dental insurance policy? Yes/No
If yes, please provide us with secondary insurance information.

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Drs. Hein & Nelson of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ Patient's Signature: _____

CONSENT:

I hereby authorize Drs. Hein & Nelson to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Drs. Hein & Nelson to make a thorough diagnosis of the patient's dental needs. I also authorize Drs. Hein & Nelson to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I allow Drs. Hein and Nelson to use photographs of my dental condition and subsequent treatment outcome for teaching and demonstration purposes. I understand that my dental insurance is a contract between myself and the insurance carrier and not between Drs. Hein & Nelson and my insurance company. I fully understand that it is my responsibility for all dental treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____ Dr. Signature _____

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____ (Date)_____
(Signature of Patient and/or Guardian)

(Relationship to Patient) Self or Other: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify)

Our Financial Policy

Regarding Insurance
We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within **30 days.**

WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS.
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL.

I understand that any unpaid balance after 30 days is charged a yearly finance charge of 12%. I further understand that this finance charge is equal to 1.0% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. I give consent for any credit check to be completed by Drs. Hein & Nelson should it be deemed necessary.**

I have read the Financial Policy. I understand, accept, and agree to this Financial Policy.

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Witness for Drs. Hein & Nelson Date

MEDICAL HEALTH HISTORY

Patient Name: _____ **Date:** _____

Name of Physician: _____ Date of Last Medical Exam: _____

CIRCLE YOUR ANSWERS:

Yes No Are you in good health?
Yes No Has there been a change in your health within the last year? Explain: _____

Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

Yes No Are you being treated by a physician now? If yes, name of physician: _____

Reason _____

PLEASE LIST ALL CURRENT MEDICATIONS, SUPPLEMENTS & VITAMINS: _____

_____

Yes No Have you ever been told by a physician or dentist that you need an antibiotic prior to any dental treatment?
If yes, for what reason/condition is it prescribed for? _____

HAVE YOU EVER EXPERIENCED?

Yes No Chest Pains
Yes No Swollen Ankles
Yes No Shortness of breath
Yes No Recent weight loss, fever, night sweats
Yes No Persistent cough, coughing up blood
Yes No Bleeding problems, bruising easily
Yes No Sinus Problems
Yes No Difficulty swallowing
Yes No Dizziness
Yes No Ringing in ears
Yes No Frequent Headaches
Yes No Fainting spells
Yes No Seizures
Yes No Blurred Vision
Yes No Jaundice
Yes No Joint pain, stiffness

DO YOU HAVE OR HAVE YOU HAD:

Yes No Contact Lenses
Yes No Heart disease
Yes No Heart attack, heart defects
Yes No Heart murmur
Yes No Rheumatic fever
Yes No Stroke, hardening of arteries
Yes No High Blood Pressure
Yes No TB, emphysema or other lung diseases
Yes No Hepatitis, A B C
Yes No Stomach problems, ulcers
Yes No Diabetes
Yes No Mitral Valve Prolapse

Yes No Surgeries _____
Yes No Blood Transfusions _____
Yes No Artificial Joint _____
Yes No Prosthetic heart valve _____

Yes No Excessive thirst
Yes No Frequent urination
Yes No Dry Mouth
Yes No Sleep apnea or chronic snoring
Yes No HIV positive or AIDS-ARC
Yes No Tumors, Cancer
Yes No Arthritis, rheumatism
Yes No Eye disease
Yes No Skin disease
Yes No Anemia
Yes No History of STD
Yes No Herpes
Yes No Kidney, bladder diseases
Yes No Thyroid, adrenal diseases
Yes No Family History of diabetes, heart problems, cancer
Yes No Fibromyalgia
Yes No Radiation Treatments
Yes No Chemotherapy
Yes No Psychiatric Care
Yes No Currently pregnant or nursing
Yes No Currently taking birth control pills

DO YOU TAKE OR HAVE YOU TAKEN:

Yes No Fosamaxx
Yes No Tobacco in any form
Yes No Phen Phen diet pills or any other diet pills
Yes No Alcohol
Yes No Recreational drugs

ALLERGIES: **LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:**

_____

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

DENTAL HEALTH HISTORY

Name of your former Dentist: _____ Former DDS Phone #:_____

How long since you were last seen? _____

On a scale of 1-10, 10 being the best, where would you rate your smile? _____
On a scale of 1-10, 10 being the best, where you rate your oral health? _____

Have you experienced any of the following problems?

Y N Bleeding gums
Y N Bad Breath or sour taste in mouth
Y N Burning sensations in mouth
Y N Soreness in jaw
Y N Is it hard for you to open wide?
Y N Clicking or popping in jaw
Y N Gum Disease
Y N Did you ever wear braces?
Y N Oral Surgery of any kind

Y N Sensitivity to Hot & Cold
Y N Snoring
Y N Food catching between teeth
Y N Clenching or Grinding of Teeth
Y N Pain/soreness around ears, eyes, face
Y N Stiff neck muscles
Y N Do you or your parents wear dentures/partials?
Y N Have you ever been injured in your mouth or head?
Y N Do you smoke or chew tobacco?

Does having dental treatment make you afraid or nervous? Y N If yes, what specific things bother you? _____

If you could change anything about your smile which of the following would you want?

Y N Whiter
Y N Replace missing teeth
Y N Remove Stains/Spots on teeth
Y N Straighter

Y N Close space or spaces
Y N Replace old crowns
Y N Excess showing of Teeth
Y N Less Gum showing

Y N Replace chipped teeth
Y N Remove silver fillings
Y N Replace old plastic filling(s)
Y N Reshape/resize my teeth

Please circle which of the following are important to you when making your dental health decision.

Convenience
Finances
What insurance covers
Fear or Anxiety

Appearance
Time
Health
Comfort

Relationship with Dental Team
Quality of care
Detailed treatment explanations
Technology

Patient Signature: _____ Date: _____