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)

Child's Last Name: ______________ First Name: ______________ Middle Initial ______________ Sex: M ________ F ________

Prefers to be called: ______________ Date of Birth: ______________

Street Address: ______________ City, State, Zip: ______________

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

Parent's e-mail Address: ______________

Parents Names: ______________ Occupations: ______________

Parent's Address (if different than above): ______________ City, State, Zip: ______________

Emergency Contact Name: ______________ Phone # : ______________

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 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: ______________ **Parent/Guardian 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 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.

Parent/Guardian 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.

____________________________________ ______________________________

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

(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: ____________________

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Is your child in good health?
2. Yes No Has there been a change in their health within the last year? Explain: ______________________
3. Yes No Has your child been hospitalized or had a serious illness in the last 2 years? Explain: ______________________
4. Yes No Is your child being treated by a physician now? For what? ______________________

B. HAS YOUR CHILD EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Ringing in ears
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever,
9. Yes No Persistent cough,
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Dizziness
14. Yes No Jaundice
15. Yes No Frequent Headaches
16. Yes No Fainting spells
17. Yes No Blurred Vision
18. Yes No Seizures
19. Yes No Excessive thirst
20. Yes No Joint pain, stiffness

C. DOES YOUR CHILD HAVE OR HAS HAD:

21. Yes No Heart disease
22. Yes No Heart defects
23. Yes No Heart murmur
24. Yes No Eye disease
25. Yes No Skin disease
26. Yes No TB, emphysema or other lung diseases
27. Yes No Hepatitis, A B C
28. Yes No Kidney, bladder diseases
29. Yes No HIV positive or AIDS-ARC
30. Yes No Tumors, Cancer
31. Yes No Rheumatic fever
32. Yes No Anemia
33. Yes No Stomach problems, ulcers
34. Yes No Thyroid, adrenal diseases
35. Yes No Diabetes
36. Yes No Mitral Valve Prolapse
37. Yes No Surgeries
38. Yes No Blood Transfusions
39. Yes No Artificial Joint
40. Yes No Contact Lenses
41. Yes No Psychiatric Care
42. Yes No Radiation Treatments
43. Yes No Chemotherapy
44. Yes No Prosthetic heart valve

45: Other: ______________________

DOES YOUR CHILD TAKE VITAMINS & MEDICATIONS? Yes/No. If yes, please list.

____

____

____

DOES YOUR CHILD HAVE ANY ALLERGIES? LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC.? Please list allergies:

____

DOES YOUR CHILD HAVE OR HAD ANY OTHER DISEASES OR MEDICAL PROBLEMS NOT LISTED ON THIS FORM? I[illegible] so please explain:

____

HAS YOUR CHILD EVER BEEN TOLD BY A PHYSICIAN OR DENTIST THAT YOU NEED TO PRE-MEDICATED PRIOR TO ANY DENTAL TREATMENT?

If yes, for what reason/condition is it prescribed for? ______________________

DENTAL HEALTH HISTORY

H. Name of your Child's Former Dentist: ___________________________ How long since he/she was last seen? _______

Yes No Is this your child's first visit to a Dentist?

Yes No Has your child had any problem(s) with dental treatment in the past?

Yes No Has your child ever received a local anesthetic?

Yes No Has your child ever had fillings and/or sealants?

Yes No Has your child ever worn braces? If so, when? ____

Yes No Does your child snack between meals? What snacks does he/she prefer? ______________________________

Yes No Does your child drink from a baby bottle or sippy cup?

Yes No Does your child suck his/her thumb/finger(s) or use a pacifier? ____________________________________

Yes No How often are you (or child) brushing your child's teeth? ____

Yes No How often do you floss his/her teeth? ____

Yes No Do you have fluoridated water at home?

Yes No Does your child take fluoride supplements? If so, what kind and how often? ___________________________

Yes No Does your child drink at least 2 glasses of water a day?

Yes No Have there been any injuries to teeth, such as a fall, etc? ____

Yes No Do you have any special concerns about your child's teeth? _______________________________________

Since heredity is a factor in dental health, how would each parent rate his/her own teeth? Excellent Good Fair Poor

Yes No Does having dental treatment make your child afraid or nervous? If yes, what specific things bother your child? ____

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

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Parent/Guardian Signature: ____ Date: _____________________