Bloom Family Dentistry **Please Complete ALL information**

Patient Information

Today's Date: _______________

Patient Name:____
Last name First Name Middle Initial

Address____

City__________________ State__________ Zip____________ Date of Birth____________

Sex: M / F SS # (required): _______________ Marital Status (circle): S M W D SEP

Phone: Cell ( ) ___________________ Work or home: ( ) _________________

E-Mail: _______________________________________ Prefer: Text E-Mail Phone Call
Please Print (circle as many as needed)

Patient Employer: ____

Employer Phone: ________________________ Occupation: _______________________

Whom may we thank for referring you? ____

Emergency Contact: _________________ Relationship:__________ Phone: ___________

Primary Dental Insurance

Subscriber Name: ________________________ Subscriber SS#: ________________

Date of Birth: ______________ Relationship to Patient: Self Spouse Child Other

Employer Name: ________________________ Employer Phone #: _________________

Insurance Company Name: _________________________ Phone: _________________

Contract/ID #: ___________________________ Group #: ______________________

Secondary Dental Insurance

Subscriber Name: ________________________ Subscriber SS#: __________________

Date of Birth: ______________ Relationship to Patient: Self Spouse Child Other

Employer Name: ________________________ Employer Phone #: _________________

Insurance Company Name: _________________________ Phone: _________________

Contract/ID #: ___________________________ Group #: _________________

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Health Information

Patient Name: ______________________ Physician's Name: _________________

Physician's Phone #: ___________________ Last Physical Date: _______________

Date of Last Dental Cleaning: __________ Reason for Today's Visit? ______________

Do you experience jaw pain? Y / N Clenching or Grinding? Y / N

Have you ever had treatment for Periodontal (gum) disease? Y / N

Have you ever taken antibiotics prior to dental procedures? Y / N

Are you allergic to latex products? Y / N Do you have any heart conditions? Y / N

If yes, please explain: ____

Do you have any of the following?

	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Epilepsy / Seizures		
Heart Murmur			Mitral Valve Prolapse			Anemia			Fainting/Dizzy Spells		
Diabetes			Pace Maker			Sinus problems			On Blood Thinners		
High Blood Pressure			Low Blood Pressure			Arthritis			Stroke		
Any type of Transplant			Knee Replacement			Hip Replacement			Cancer (type)		
Chemotherapy			Radiation Therapy			Dialysis			Lung Disease		
Breathing Problems			Tuberculosis (TB)			Liver Disease			Kidney Disease		
Blood Transfusion			Hepatitis (type)			HIV Positive/ AIDS			Chemical Dependency		
Tobacco Use											

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Women:	Y	N					Y	N		Y	N
Is there a possibility of pregnancy?			Due Date:________ ____			Are you Nursing?			Are you taking birth control prescriptions?		

NOTE: Antibiotics (such as Penicillin) may alter the effectiveness of birth control medication. Consult your OB/GYN for assistance regarding additional methods of birth control.

List any medications you may be allergic to:____

List any medications you are taking:____

____

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist and/or hygienist to perform an examination and diagnose and/or treat my condition. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature ____ Date: ____________________

Authorization for Release of Dental Records to External Parties (Family Only)

I authroize the disclosure of information from my treatment records to:

Name of Recipient: _________________________________ Relation: _______________

I give authorization to disclose the following infromation:

_____ All treatment information

_____ Information specifically related to these treatment dates

Starting Date: ____________________ Ending Date: ____________________

I understand that I may withdraw or revoke my permission at anytime. I may revoke this authorization by notifying Dr. Bloom's practice in writing.

Patient's Signature____ Date: ______________

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FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Our fees are reasonable and customary in accordance with other specialist offices in this area.

Payments: We accept cash, debit cards, Visa, Mastercard , Discover, Care Credit and personal Checks with a photo ID. After services have been rendered, we will bill your insurance company and all co-payments are expected at time of service and may be asked for prior to seeing the dentist.

Returned checks: All returned checks will be assessed a 47.00 return check fee. You will have 10 days to pay back the outstanding check and the return check fee, the check will be sent to a collections agency. In addition, we only will accept cash or credit card for any future visits.

Re-biling Fees: A re-billing fee of 22 % interest will be imposed on each account that is over thirty (30) days past due.Unless arrangements are approved in writing, your account will be billed a re-billing fee.

Insurance: Your insurance is a contract between you and your insurance company. Dr. Casey Bloom is not responsible for non-covered services or services rendered without proper referral authorization, or denied services. We will file your insurance and collect the patient responsible portion. Please remember, if your insurance denies payment, the dispute remains between you and your insurance company. It is your responsibility to pay your bill and contact your insurance regarding the denial of the claim.
We will not change diagnosis codes in order to get your claim paid unless it is documented in the chart by your doctor, as it is illegal to do so. If your insurance does not cover certain procedures or office visits,

Insurance Changes: Many insurance companies have *Timely Filing Deadlines*. It is your responsibility to inform us of any insurance changes. If we are not provided with accurate information at the time of service, you may be responsible for the payment in full for all services rendered. It is the patient's responsibility to know if Dr. Casey M. Bloom is a valid provider with your insurance company.

Regarding Out-Of-Network: We try to verify all patient's insurance benefits before you are seen by the dentist. If you are out of network, please be advised that you will be responsible for the full amount that your insurance doesn't pay at the time of the visit.

Collections Agency: Any outstanding balances are due within 30 days of the statement. The second and each subsequent statement maybe assessed a 22% interest Rebilling Fee. All balances reaching 90 day past due may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees our office incurs through the process utilized to collect the delinquent balance.

Transferring of Records: You will need to request, in writing, the transfer of your records and allow 48 hour notice before records will be available- copies of your records will be sent to another doctor or organization.

Missed Appointments: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request you notify our office 24 hours in advance, there will be a $50 fee for this appointment applied to your account.

I have read and agree to the above Financial policy. I understand that I am financially responsible for all charges incurred by me for dental services rendered to me by Dr. Casey M. Bloom.

Patient or Responsible Party Signature: ___________________________________Date_____________