Patient Information

BLUE EARTH & MAPLETON FAMILY DENTAL

General Patient Information

First Name_____ Middle Initial _____ Last Name _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

Address _____

Home Phone_____-_____-_____ Cell Phone _____-_____-_____

Other _____-_____-_____ Circle Preferred: HOME or CELL or OTHER

Email Address _____

Marital Status _____

Employer or School _____ Occupation _____

How did you hear about us? _____

	Text	Call	Email
How would you like Appointment Reminders?			
How would you like Routine Cleaning Reminders?			

Dental Insurance Information

Is there Dental Insurance that we can file on your behalf? _____

If yes, please present card for photo copy.

Emergency Notification Information

In case of emergency, who should we contact?

Name _____ Phone _____-_____-_____ Relation _____

Please sign that you received our Privacy Policy

Signature _____ Date _____/_____/_____

Initial Health History

BLUE EARTH & MAPLETON FAMILY DENTAL

Patient Information

First Name _____ Last Name _____ Date of Birth _____

Primary Guardianship (if applicable) Name _____Contact _____-_____-_____

Are you currently under the care of a physician? YES or NO Date of last Physical Exam ____/_____/_____

Physician's Name/Location _____ Reason _____

Have you ever had a serious illness, operation, or been hospitalized? *Please explain briefly*

_____

Have there been any changes in your health in the last two years? *Please explain briefly*

_____

Are you allergic to any medications, foods, latex, or products? _____

Have you ever been treated for any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure			Artificial Joint			Tuberculosis			Cancer		
Low Blood Pressure			Heart Disease			Heart Valve			Stroke		
Rheumatic Fever			Fibromyalgia			Hepatitis			Asthma		
Immunocompromised Disease			Heart Murmur			Diabetes			Dry Mouth		
Bleeding/Clotting Disorder			Osteoporosis			Depression			Other		

Do you now or have you ever used tobacco products? Yes, currently _____ Yes, in the past _____ Never _____

Have you been told you should take a premedication antibiotic before dental treatment? _____

Are you currently taking any blood thinner? _____Name of medication _____

Have you ever been treated for sleep apnea? _____Do you currently use a CPAP machine?_____

Women Only: Are you pregnant or do you think you may be pregnant? _____ Are you taking birth control pills? _____

Current Medications: Prescribed and non-prescribed *If you have a list, we can make a copy*

_____

_____

_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status.

Signature _____ Date _____/_____/_____

If you have completed this form for another person, please print your name and sign below along with your relationship

Print _____ Relationship _____

Signature _____ Date _____/_____/_____

Blue Earth & Mapleton Family Dental
519 S Galbraith St.
Blue Earth, MN 56013
officemanager@blueearthfamilydental.com
Phone: 507-526-3111 or 507-524-3830

Financial Agreement

Thank you for choosing ***Blue Earth & Mapleton Family Dental*** as your dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Below are details for our Financial Policy and Patient Responsibilities:

- All patients must complete informational, health history, and insurance forms before seeing the doctor.
- Full Payment is due at the time of service for all treatments. This includes non-insured patients as well as patients with out of network insurance.
- For your convenience we accept cash, personal check ($25 charge applied to account for any returned checks), or Visa/MasterCard/Discover.
- We accept Care Credit as a full payment option. Care Credit is an outside payment plan company that you must apply for on your own. Please ask the front desk for information on how to apply (patient applies on their own).

PATIENTS WITH INSURANCE COVERAGE

We file service claims on your behalf to your dental insurance that you provide to us at each visit. We are able to file with most plans. We are a in network premier provider for Delta Dental plans. All other carriers we are out of network with and reimbursements will be sent to you directly. We are not a part of or are able to submit claims to any state/government plans. The balance incurred is your responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy and this office cannot guarantee the amounts of coverage offered by your insurance carrier. It is your responsibility to seek coverage limits and liability of your insurance policy. Your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and likewise will not be held responsible in the event your insurance company denies any claims. Any remaining balances not covered by insurance will be billed to you and must be paid within 30 days.

DELINQUENCY (over 90 days past due)

In the event your account is referred to an outside agency or attorney, you will be responsible for the collection costs. In the event your account needs to be referred to an outside agency, you give Blue Earth & Mapleton Family Dental permission to give the agency any personal information in relation to the collection of your account. Payments may only be made to the collection agency once sent. You will no longer be able to receive services from our office.

I have read and understood Blue Earth & Mapleton Family Dental Financial Agreement.

Printed Name: _____ Date: _____

Signature of Patient or Responsible Party: _____

HIPAA Notice of Privacy Practices
Blue Earth & Mapleton Family Dental
519 S. Galbraith St. Blue Earth, MN 56013
102 NE Main St Mapleton, MN 56065

KEEP FOR YOUR RECORD

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

When it comes to your health information, you have certain rights:

- • Get a copy of your paper or electronic chart, including confidential information
- • Correct your paper or electronic dental record
- • Ask us to limit the information we share
- • Get a list of those with whom we have shared your information
- • Get a copy of this privacy notice
- • Choose someone to act on your behalf
- • File a complaint if you believe your rights have been violated

We may use and share your information as we:

- • Treat you
- • Bill for your services
- • Address workers' compensation, law enforcement and other government requests
- • Respond to lawsuits and legal actions
- • Run our organization
- • Comply with the law
- • Work with medical examiner or funeral director

This sections explains your rights and some of our responsibilities to help you:

- • You can ask to see or get an electronic or paper copy of your dental record and other health information we have about you.
- • We will provide a copy or a summary of your health information, usually within 30 days of your request.
- • We may need to say "no" to your request, but we'll have to tell you why in writing within 60 days.
- • You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- • If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights to make choices about your dental health information. We will make sure the person has this authority and can act for you before we take any action.
- • You can complain if you feel we have violated your rights by contacting us at the address provided. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil/Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa complaint.
- • We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- • Share information with your family, close friends, or others involved in your care.
- • If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- • We will never share your information unless you give us written permission.

We typically use or share health information in the following ways to:

- • Treat you – We can use your health information and share it with other professional who are treating you. Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*
- • Run our organization – We can use and share your dental health information to run our practice, improve your care, and contact you when necessary. Example: *We use health information about you to manage your treatment and services.*
- • Bill for your services – We can use and share your information to bill and get payment from insurance plans or other entities Example: *We give information about you to your dental insurance plan so it will pay for your services.*

How else can we use or share your dental information?

- • Preventing disease
- • Helping with product recalls
- • Reporting adverse reactions to medications
- • Preventing or reducing a serious threat to anyone's health or safety
- • Comply with the law: We will share information about you if state or federal law require it.
- • Work with a medical examiner, coroner or funeral director.
- • To address workers' compensation, law enforcement, and other government requests.
- • For special government functions such as military.
- • Reply to lawsuits and legal actions by responding to court or administrative order, or a subpoena.

Our Responsibilities

- • We are required by law to maintain the privacy and security of your protected information.
- • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- • We must follow the duties and privacy practices described in this notice and give you a copy of it.
- • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to Terms of this Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website. For more information see: www.hhs.gov/ocr/privacy/hipaa/understaning/consumers/noticepp.html