Bloom
DENTAL
OF CHESTERFIELD

WELCOME TO BLOOM DENTAL. We appreciate your confidence in us to provide dental care for you and your family. All information on this form is necessary for our records and is strictly confidential.

Patient Name _____

Address _____ City _____ State_____

Zip Code _____ Phone: Home _____

Work: _____ Cell: _____

Date of Birth _____ SS#_____

E-mail _____

Responsible Party if other than patient:

Name _____ Date of Birth _____

Address _____ City_____ State _____

Zip Code _____ Phone _____ Relationship _____

INSURANCE INFORMATION

Policy Holder Name _____Relationship _____

Date of Birth _____ ID#_____

INSURANCE COMPANY _____

Phone Number _____

How did you hear about us? (Check all that apply): ____ Friend/Family Referral
____Doctor Referral ____Insurance Provider ____Other:_____

HEALTH HISTORY

Are you under a physician's care now?	O Yes	O No	If yes, _____
Have you been hospitalized or had a major operation?	O Yes	O No	If yes, _____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, _____
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes, _____
Are you on a special diet?	O Yes	O No	If yes, _____
Do you use tobacco?	O Yes	O No	If yes, _____
Are you on an aspirin regimen?	O Yes	O No	If yes, _____
Has a doctor ever told you to take antibiotics prior to dental treatment?	O Yes	O No	If yes, _____

Women: Are you…

O Pregnant/Trying to get pregnant? O Nursing? O Taking oral contraceptives?

Are you allergic to any of the following?

O Aspirin	O Penicillin	O Codeine	O Acrylic	O Other?_____
O Metal	O Latex	O Sulfa Drugs	O Local Anesthetics	_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes	O No	Emphysema	O Yes	O No	Irregular Heartbeat	O Yes	O No
Alzheimer's Disease	O Yes	O No	Epilepsy or Seizures	O Yes	O No	Kidney Problems	O Yes	O No
Anemia	O Yes	O No	Excessive Bleeding	O Yes	O No	Leukemia	O Yes	O No
Angina	O Yes	O No	Excessive Thirst	O Yes	O No	Low Blood Pressure	O Yes	O No
Arthritis / Gout	O Yes	O No	Fainting	O Yes	O No	Liver Disease	O Yes	O No
Artificial Heart Valve	O Yes	O No	Spells/Dizziness	O Yes	O No	Lung Disease	O Yes	O No
Artificial Joint	O Yes	O No	Frequent Headaches	O Yes	O No	Mental/Psychiatric Care	O Yes	O No
Asthma	O Yes	O No	Frequent Cough	O Yes	O No	Mitral Valve Prolapse	O Yes	O No
Blood Disease	O Yes	O No	Glaucoma	O Yes	O No	Radiation Treatments	O Yes	O No
Blood Transfusion	O Yes	O No	Hay Fever	O Yes	O No	Renal Dialysis	O Yes	O No
Breathing Problems	O Yes	O No	Hepatitis A	O Yes	O No	Rheumatic Fever	O Yes	O No
Bruise Easily	O Yes	O No	Hepatitis B or C	O Yes	O No	Rheumatism	O Yes	O No
Cancer	O Yes	O No	Hemophilia	O Yes	O No	Scarlet Fever	O Yes	O No
Chemotherapy	O Yes	O No	Herpes	O Yes	O No	Sinus Trouble	O Yes	O No
Chest Pains	O Yes	O No	High Blood Pressure	O Yes	O No	Shingles	O Yes	O No
Cold Sores/Fever Blister	O Yes	O No	High Cholesterol Hives	O Yes	O No	Stroke	O Yes	O No
Congenital Heart Dis.	O Yes	O No	or Rash Hypoglycemia	O Yes	O No	Tuberculosis	O Yes	O No
Cortisone Medicine	O Yes	O No	Heart Attack/Failure	O Yes	O No	Tumors or Growths	O Yes	O No
Diabetes	O Yes	O No	Heart Murmur	O Yes	O No	Osteoporosis	O Yes	O No
Drug Addiction	O Yes	O No	Heart Disease/Trouble	O Yes	O No	Pain in Jaw Joints	O Yes	O No
Easily Winded	O Yes	O No	Heart Pacemaker	O Yes	O No	Ulcers	O Yes	O No

Have you ever had a serious illness not listed above? O Yes O No *If yes*, _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to me or your staff's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date _____

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FINANCIAL AND HIPPA DISCLOSURE

Please be advised that your Dental Insurance Plan is a contract between you, your Employer, and the Insurance Company. We are not a party to the contract. You are responsible for monitoring your own policy. As a courtesy we will file dental claims on your behalf, however, the final payment is decided by your insurance company. Please bring any changes to your policy to the attention of the Front Desk Team. If payment is not received from the insurance company within 35 business days, you will be responsible for the balance. A fee of 5% is added to all unpaid balances after 21 days from the first written notice. If your account goes to collections, you will be responsible for all collection fees. I authorize payment from my insurance company to be paid directly to Dr. Crystal Joyce of Bloom Dental of Chesterfield.

In order to adhere to the scheduling needs of our patients, we require 48 hours' notice to cancel or reschedule a dental appointment; Otherwise, a broken appointment fee of $100.00 will be imposed.

HIPPA CONSENT AND DISCLOSURE

By signing this form you will consent to our use and disclosure of your protected information to carry out the treatment in accordance with Section 32.1-45.1 of the code of Virginia. Please understand you have the right to revoke this consent. However, we may decline to treat you if you revoke this consent. I understand that by signing this form I give consent to your use of my protected information to file dental claims on my behalf. I will adhere to the conditions stated above on the Financial Disclosure.

Patient/Guardian Signature: _____ Date _____

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UNDERSTANDING YOUR INSURANCE COVERAGE

At Bloom Dental, we're happy to file all dental insurance claims on your behalf as a courtesy. We are in-network with many major insurance providers and strive to help you maximize your benefits. However, it's important to understand that **dental insurance is designed to assist with the cost of care—it typically does not cover treatment in full.**

Some insurance companies simply do not reimburse enough to cover the full cost of materials and quality care we provide. For this reason, we recommend that you take time to review and understand your specific dental plan by contacting your dental insurance provider directly. While we do our best to provide accurate out-of-pocket estimates before your visit ends, please note that employers can choose from dozens of plan options with varying coverage details. Because we are not directly involved in selecting or managing your benefits, we may not have access to all plan-specific limitations.

At Bloom Dental, we make treatment recommendations based on your **i**ndividual needs—not just what your insurance plan may cover. In many cases, insurance plans are designed more to reduce employer costs than to provide comprehensive coverage. There are several reasons you may receive a bill after your claim has been processed, including:

- Waiting periods
- Missing tooth clauses
- Downgrading of molar restorations
- Non-duplication clauses for dual coverage
- Procedures not covered under your plan

We work hard to gather as much information as possible prior to your first visit. However, insurance companies don't always provide full plan details in advance, which can lead to unexpected coverage gaps. If you ever have questions, we're here to help you navigate your benefits and make informed decisions about your care.

Patient / Guardian Signature _____ Date _____