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:_____

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, _____
Do you need to be pre-medicated?	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 Metal O Latex O Sulfa Drugs O Local Anesthetics

O Other? _____

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 Spells/Dizziness	O Yes O No	Liver Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Frequent Headaches	O Yes O No	Lung Disease	O Yes O No
Artificial Joint	O Yes O No	Frequent Cough	O Yes O No	Mental/Psychiatric Care	O Yes O No
Asthma	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No
Blood Disease	O Yes O No	Hay Fever	O Yes O No	Radiation Treatments	O Yes O No
Blood Transfusion	O Yes O No	Hepatitis A	O Yes O No	Renal Dialysis	O Yes O No
Breathing Problems	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatic Fever	O Yes O No
Bruise Easily	O Yes O No	Hemophilia	O Yes O No	Rheumatism	O Yes O No
Cancer	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Chemotherapy	O Yes O No	High Blood Pressure	O Yes O No	Sinus Trouble	O Yes O No
Chest Pains	O Yes O No	High Cholesterol	O Yes O No	Shingles	O Yes O No
Cold Sores/Fever Blister	O Yes O No	Hives or Rash	O Yes O No	Stroke	O Yes O No
Congenital Heart Dis.	O Yes O No	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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X_____ 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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INSURANCE AND WHAT YOU NEED TO KNOW:

AS A COURTESY TO OUR PATIENTS, BLOOM DENTAL WILL FILE ANY INSURANCE COMPANY ON YOUR BEHALF. WE ARE A PREFERRED PROVIDER WITH MANY INSURANCE COMPANIES. UNFORTUNATELY, SOME INSURANCE COMPANIES SIMPLY DO NOT PAY DENTAL PROVIDERS ENOUGH TO COVER THE COST OF MATERIALS AND LABOR FOR A PROCEDURE.

DENTAL INSURANCE GENERALLY OFFSETS THE COST OF TREATMENT BUT, DOES NOT PAY FOR IT ENTIRELY. THAT IS WHY IT IS SO IMPORTANT FOR YOU TO "KNOW YOUR DENTAL PLAN."

WE DO OUR BEST TO ESTIMATE YOUR OUT-OF-POCKET COST BEFORE YOU LEAVE OUR OFFICE. PLEASE REMEMBER THERE ARE DOZENS OF PLANS THAT YOUR EMPLOYER CAN PURCHASE. WE ARE NOT PARTY TO MANY DETAILS OF YOUR PLAN THEREFORE WE ENCOURAGE YOU TO "KNOW YOUR DENTAL PLAN".
AT BLOOM DENTAL WE PROVIDE TREATMENT BASED ON WHAT YOU NEED, NOT BASED ON WHAT YOUR INSURANCE COMPANY COVERS. MANY EMPLOYERS CHOOSE A DENTAL PLAN TO REDUCE THEIR COST.

THERE ARE A NUMBER OF REASONS WHY YOU MAY RECEIVE A BILL FROM US AFTER THE INSURANCE CLAIM IS SETTLED. WAITING PERIODS, MISSING TOOTH CLAUSE, MOLARS ARE DOWNGRADED, A NON-DUPLICATION CLAUSE FOR DUAL COVERAGE, THE PROCEDURE IS NOT A COVERED BENEFIT. WE TRY TO GATHER ALL THIS INFORMATION FOR YOU PRIOR TO YOUR VISIT HOWEVER MANY INSURANCE WEBSITES OR FAX DOES NOT GIVE THIS INFORMATION TO THE PROVIDER.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____