



# New Patient-Welcome!

Date: \_\_\_\_\_ How did you hear about Bloom? \_\_\_\_\_

## PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Gender: Male/Female  
 Patient's Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Gender: Male/Female  
 Patient's Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Gender: Male/Female  
 Patient's Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Gender: Male/Female

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_

What school does your child attend? \_\_\_\_\_

## LEGAL GUARDIAN INFORMATION

1. Legal Guardian's Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_  
 Relationship to patient (circle): Father Mother Step-Parent Grandparent Other \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_  
 Marital Status: Single Married Divorced Widowed Other:  
 Spouse's Name: \_\_\_\_\_  
 Complete if different from patient:  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

2. Legal Guardian's Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_  
 Relationship to patient (circle): Father Mother Step-Parent Grandparent Other \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_  
 Marital Status: (circle): Single Married Divorced Widowed Other:  
 Spouse's Name: \_\_\_\_\_  
 Complete if different from patient:  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

## EMERGENCY CONTACT

In case of an emergency in which parent(s) or legal guardian(s) cannot be reached, please provide a contact.

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_



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### CAREGIVER CONSENT

Bloom Pediatric Dentistry requires a parent/legal guardian to accompany children to their dental appointment. If a legal guardian is unable to be present, please provide names of caregivers you give permission to make medical, dental, and financial decisions for this patient (must be at least 18 years old).

1. Caregiver's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

2. Caregiver's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

I, \_\_\_\_\_, the legal guardian of \_\_\_\_\_, authorize the caregiver above to accompany and make medical/dental decisions as needed for the patient. I also accept all financial responsibility for any dental procedures completed under the caregiver's supervision.

\_\_\_\_\_  
**Printed Name**                      **Signature of Legal Guardian**                      **Date**

### HIPAA ACKNOWLEDGEMENT

#### ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY POLICY PRACTICES

I acknowledge that I have been provided a copy of Bloom's **HIPAA Notice of Privacy Policy Practices**.

\_\_\_\_\_  
**Printed Name** of Legal Guardian/Patient                      **Signature** of Legal Guardian                      **Date**

**Please Note: it is your right to refuse to sign this acknowledgement.**



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## FINANCIAL & INSURANCE INFORMATION

### Primary Dental Insurance

Policy Holder's Name: \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insurance Phone #: (\_\_\_\_) \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Secondary Dental Insurance (If Applicable)

Policy Holder's Name: \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insurance Phone #:(\_\_\_\_) \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Medical Insurance (AHCCCS)

Patient's Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
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Patient's Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Plan Name: \_\_\_\_\_

I understand that I am financially responsible for all charges whether or not paid by insurance and agree to reimburse Bloom Pediatric Dentistry the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees Bloom Pediatric Dentistry incurs in such collection efforts.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If you have insurance, please fill out the following statement:*

I certify that my minor/child is covered by insurance with \_\_\_\_\_(Name of Insurance Company) and assign directly to Bloom Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I have been informed whether my insurance is in or out of network. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I have received a copy of the practice's Financial Policy.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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## MEDICAL HISTORY

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do you have a Pediatrician, physician or clinic you attend?  Yes  No Doctor's Name: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, explain: \_\_\_\_\_

Have you ever had a serious head or neck injury  Yes  No If yes, explain: \_\_\_\_\_

Are you taking any medications, vitamins or drugs?  Yes  No If yes, explain: \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, explain: \_\_\_\_\_

Are you up to date on all immunizations?  Yes  No

Are you **allergic** to any of the following?  No known drug allergies  No known food allergies

Penicillin  Sulfa drugs  Clindamycin  Local anesthetics  Acrylic

Latex  Amoxicillin  Codeine  Adhesive tape  Metal

Other Allergy \_\_\_\_\_ If YES any, please explain \_\_\_\_\_

*Please answer each of the following. Has your child ever had any of the following health problems?*

Heart defect/disease, heart murmur, rheumatic fever or rheumatic heart disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular heart beat or high blood pressure .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinusitis, chronic adenoid/tonsil infections .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep apnea/snoring, mouth breathing, or excessive gagging .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma, reactive airway disease, wheezing or breathing problems .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic fibrosis .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent colds or coughs, or pneumonia .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent exposure to tobacco smoke .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaundice, hepatitis or liver problems .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastroesophageal/acid reflux disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lactose intolerance, food allergies, nutritional deficiencies or dietary restrictions .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concerns with weight, or eating disorder .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder or kidney problems .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rash/hives, eczema or skin problems .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Impaired vision, hearing, or speech .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental disorders, learning problems/delays, or intellectual disability .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism/Autism spectrum disorder .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recurrent or frequent headaches/migraines, fainting or dizziness.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADHD .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes, hyperglycemia or hypoglycemia .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Precocious puberty or hormonal problems .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid or pituitary problems .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia, sickle cell disease/trait, or blood disorder .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia, bruising easily or excessive bleeding .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transfusions or receiving blood products .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, tumor, other malignancy chemotherapy, radiation therapy or bone marrow or organ transplant .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), Methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV/AIDS) .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

Provide details here: \_\_\_\_\_

Is there any other condition in the child's medical history not listed?  Yes  No Explain: \_\_\_\_\_

Parent/Guardian Signature & Date: \_\_\_\_\_ Doctor Signature & Date: \_\_\_\_\_

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### DENTAL HISTORY

Has your child ever had a dental visit?  Yes  No

Previous Dentist Name: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

Were x-rays taken of the teeth and jaws?  Yes  No  Unsure Date of last xrays: \_\_\_\_\_

Has your child experience any unfavorable reaction form previous dental care?  Yes  No

Explain: \_\_\_\_\_

**Do you have a concern with any of the following? (Check all that apply)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Pain from teeth or mouth | <input type="checkbox"/> Injury to teeth or gums | <input type="checkbox"/> Crowded teeth                     |
| <input type="checkbox"/> Cavities                 | <input type="checkbox"/> Poor brushing habit     | <input type="checkbox"/> Finger, thumb, or pacifier habits |
| <input type="checkbox"/> Infection                | <input type="checkbox"/> Cold Sores/Canker Sores | <input type="checkbox"/> Grinding                          |

If yes, please explain: \_\_\_\_\_

**Fluoride and Diet History:**

Does your child primarily drink (check all that apply):  Tap water  Bottled Water  Fluoridated water  Milk  Juice

Soft drinks (Soda, Gatorade, Powerade, Energy drinks, etc.)

Does you child receive fluoride in another form (pediatrician or school)

How frequently does your child have the following?

- Candy or other sweet  Rarely  1-2 times/day  3 or more times/day Candy type: \_\_\_\_\_
- Chewing gum  Rarely  1-2 times/day  3 or more times/day Brand: \_\_\_\_\_
- Snacks between meals  Rarely  1-2 times/day  3 or more times/day Usual snack: \_\_\_\_\_

How often does your child brush his/her teeth? \_\_\_\_\_ times per \_\_\_\_\_. Does someone help your child brush?  Yes  No

What toothpaste does your child use? \_\_\_\_\_

Does your child participate in any sports?  Yes  No Is a mouth guard worn during these activities?  Yes  No

### Consent For Dental Treatment

I request and authorize Dr. Janelle Lee to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Lee to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic and educational purposes. I understand the dental treatment for my children includes the effort to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Lee will provide an environment likely to help children learn to be cooperative during treatment by using praise, explanation, demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any changes incurred on this child for dental treatment.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### BLOOM PEDIATRIC DENTISTRY'S FINANCIAL POLICY

Welcome to Bloom Pediatric Dentistry! It is our primary goal and responsibility to help our patients obtain optimal dental health. We wish to direct our time and energy toward obtaining that goal. We have prepared this letter so that you may be aware of our financial policy.

Payment in full is expected at the time of treatment. Patients with dental insurance must provide accurate and complete insurance information. We will be happy to file for your insurance benefits as a courtesy to you, but we are not obligated to do so. Our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you and the insurance company. The percentage covered for each procedure is determined by how much you or your employer has paid for coverage.

Our office does not determine your dental benefits. Most plans routinely pay between 50-75% of the average total fee; however, some insurance carriers will not reimburse our office. In such instances, you will be responsible for the full cost of each visit at the time services are provided, and your insurance company will send you the reimbursement check directly.

We provide our patients with the finest treatment available and base treatment recommendations on what will be best for your child rather than what your insurance company does or doesn't pay. Our primary goal is to provide your child with the best possible treatment in a safe environment, using high quality supplies and medications. Unfortunately, the goal of many insurance companies is only to treat patients in the cheapest manner, not necessarily the safest or most effective.

At the initial appointment, you will be responsible for your portion of the fees not covered by your insurance for that appointment and payment is expected. Prior to completing any restorative treatment, however, we will provide you with a cost estimate of our total fee, your estimated insurance coverage, and your estimated out-of-pocket costs. Please remember, these are only estimates and may change during the course of treatment. Sometimes, treatment alternatives become necessary for various reasons, which may increase or decrease treatment costs. Further, most insurances do not tell us exactly what they will pay so we can only give you our best estimate.

Any amount not covered by your insurance company is payable at the time services are rendered. These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. For your convenience we accept cash, Visa/MasterCard and Care Credit.

We cannot accept responsibility for negotiating a disputed claim and allow a maximum of 45-days for your insurance company to clear account balances. If your insurance does not pay within 45 days of the treatment rendered, we shall expect a payment in full from you. A late charge of 18% will be added to unpaid balances over **60 days** past due. After 90 days from the time of service and attempts to collect outstanding funds parents/guardians not fulfilling their financial obligation will be sent to collections. You are financially responsible for all charges whether or not paid by insurance. You will be assessed the fees of any collection agency, which may be based on a percentage at maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees Bloom Pediatric Dentistry incurs such collection efforts.



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### BLOOM PEDIATRIC DENTISTRY OFFICE POLICIES

1. \_\_\_\_\_ I understand the financial policy of Bloom Pediatric Dentistry. It is my responsibility to provide information necessary to process an insurance claim. Ultimately, it is up to me to know my insurance benefits. It is my responsibility to notify Bloom Pediatric Dentistry if there is a change in my insurance coverage, residency or phone number. Treatment plans presented in office are always an estimate of what the insurance will cover, based on the information the insurance has provided. Payment is due at the time of service regardless of who is accompanying the child.
2. \_\_\_\_\_ I understand that minors must be accompanied by a responsible party, 18 years old or older, to be treated at Bloom Pediatric Dentistry. If the child is present with someone other than a parent/guardian, we must have a copy of the appropriate legal documents and/or a signed Caregiver Consent form.
3. \_\_\_\_\_ I will call the office at least **48 business hours** prior to my appointment to reschedule. If I am unable to keep my child's rescheduled appointment, I understand that failure to show up to my child's scheduled appointment constitutes as a NO SHOW, and a cancellation fee of \$50 for routine appointments and up to \$100 for dental treatment may apply.
4. \_\_\_\_\_ I will turn off my cell phone during my appointment. As the use of cell phones has grown, we have become aware of how they can interfere with communication between the patient and doctor, as well as patient privacy. Because of this, cell phone use is not permitted in patient areas.
5. \_\_\_\_\_ I understand that **no photos or videos are permitted in the clinic areas** to protect the privacy rights of all of our patients and our staff. We are a "covered entity" and are abiding by the HIPAA regulations as such. We have a designated photo op area where we allow photos to be taken. Thank you for your cooperation and understanding.
6. \_\_\_\_\_ I understand there may be a charge of \$20 for processing requests for records, made voluntarily by the patient or guardian. The payment for completion of these forms will be collected at the time of request.

***I have read and understand the above policies of Bloom Pediatric Dentistry.***

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Printed Name of Legal Guardian

\_\_\_\_\_  
Date

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### How Dental Insurances Actually Work

For starters, there are no perfect dental insurance policies. Even in the best possible scenario, dental insurances will cover only 50-75% of certain dental treatments. This percentage is based upon how much your employer has provided to its employees for this specific benefit. Bloom Pediatric Dentistry has no control over how your insurance policy provides coverage for treatment. Should you be unhappy with your particular coverage, please contact your employer's human resource department to inquire about possible policy changes or upgrades. After the treating doctor establishes a treatment option for your child, an office administrator will then thoroughly review the doctor's recommended treatments, answer any clinical or financial questions and will present your expected financial obligation. An "EPP" or estimated patient portion will be presented to you, which is the anticipated amount that you will be responsible for and is based upon the latest information provided by your insurance company regarding your particular policy. However, this amount is strictly an **estimate** and very often is **not** what they will inevitably pay. Insurance companies refuse to provide dentists with the exact amount they will pay for a procedure as they maintain the ability to sporadically change their coverage in order to manage their company's overhead. It is also important to understand that most policies have specific dental procedures that they will simply **not** cover at all. Should your particular policy not cover our provided treatments in the manner that we presented during the diagnostic phase of treatment, we apologize in advance and ask for your understanding, as we are, unfortunately, limited by how precise our estimates can be. Very often our estimates are correct or very close, but regrettably, insurance companies are deliberately deceptive during this process, which makes it impossible to obtain an exact, up-to-date amount until only after the claim has been processed. Because of this, you can expect to receive an updated billing statement from our office after your insurance company has paid its portion. This bill will be sent approximately 4-12 weeks after your visit, as insurance companies tend to take an extended period of time to settle such claims. Because of this, we appreciate you settling such remaining balances at your soonest convenience.

At Bloom Pediatric Dentistry, we always try to work within the boundaries established by your specific dental policy but feel it is our ethical duty to present recommendations based upon what is truly best for your individual child, regardless of your policy's specific coverage. Should the financial burden of a recommended treatment be a burden, please feel free to inquire about any possible alternative treatment that may be covered by your particular policy. The treating doctor or treatment coordinator will review these possible options, if any exist.

As a courtesy to our patients & parents, we will be filing your insurance claims on your behalf. Though many local dental providers require patients pay the full amount for treatment in advance and ask that they file their own claim, we believe that this can cause much confusion and frustration. In so, we are happy to complete this arduous step for you and appreciate your help in maintaining accurate and up-to-date information regarding your particular policy.

*As always it is our primary goal to provide you and your family with the best treatment and service possible. Please feel free to contact us with any dental insurance questions or concerns and a financial coordinator will be happy to help with this sometimes-confusing subject.*





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### MEDIA RELEASE FORM

I, the undersigned, do hereby consent and agree that Bloom Pediatric Dentistry, its employees, or agents have the right to take photographs, videotape, or digital recordings of my child, and to use these in any and all media, now or hereafter known, and exclusively for the purposes of social media and marketing. I further consent that the patient's first name only and identity may be revealed therein or by descriptive text or commentary. Verbal request to the legal guardian will be asked prior to proceeding by a staff member of Bloom Pediatric Dentistry.

I do hereby release to Bloom Pediatric Dentistry, and its employees all rights to exhibit this work in print and electronic form publicly or privately and to market. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording my child, either for initial or subsequent transmission or playback.

I also understand that Bloom Pediatric Dentistry is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the forgoing statement, and am competent to execute this agreement.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of child