New Patient-Welcome!

Date: ____________ How did you hear about Bloom? __________________________________

PATIENT INFORMATION

Patient's Name: ________________________ Nick Name: ___________ D.O.B.___/____/____Gender: Male/Female/Other- specify: __________

What pronouns do you prefer we use when interacting with your child? (please circle): she/her/hers, he/him/his, they/them/theirs

Patient's Name: _________________________Nick Name: ___________ D.O.B.___/____/____Gender: Male/Female/Other-specify: __________

What pronouns do you prefer we use when interacting with your child? (please circle): she/her/hers, he/him/his, they/them/theirs

Patient's Name: ________________________ Nick Name: ___________ D.O.B.___/____/____ Gender: Male/Female/Other-specify: __________

What pronouns do you prefer we use when interacting with your child? (please circle): she/her/hers, he/him/his, they/them/theirs

Patient's Name: ________________________ Nick Name: ___________ D.O.B.___/____/____Gender: Male/Female/ Other-specify: __________

What pronouns do you prefer we use when interacting with your child? (please circle): she/her/hers, he/him/his, they/them/theirs

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 # (______) __________________________

New Patient-Welcome!

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 RECIEPT 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.

New Patient-Welcome!

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: ________________________

Patient's Name: ________________________ ID#: _____________________ Plan Name: ________________________

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:** ____________________________

Bloom
Pediatric Dentistry

New Patient-Welcome!

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?

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

Bloom Pediatric Dentistry, PLLC
Office of Dr. Janelle Lee

Bloom
Pediatric Dentistry

New Patient-Welcome!

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 x-rays: _______________________________

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

Explain: ____

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

☐ Pain from teeth or mouth ☐ Injury to teeth or gums ☐ Crowded teeth

☐ Cavities ☐ Poor brushing habit ☐ Finger, thumb, or pacifier habits

☐ Infection ☐ Cold Sores/Canker Sores ☐ 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 your 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:** _______________________________

New Patient-Welcome!

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 minimal charge 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

New Patient-Welcome!

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.

New Patient-Welcome!

Bloom
Pediatric Dentistry

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.