Platt Dentistry

11183 205th Street West. Lakeville, MN 55044. 952.469.4588

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ Social Security #:_____

Phone (Home): _____ (Work): _____ (Cell): _____

Email address: _____

Address: _____
Street

_____
City State Zip Code

Employer: _____ Employer Phone: _____

RESPONSIBLE PARTY INFORMATION

Who is the responsible party for this account? _____

Please fill the following information, if different than above.

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Relationship to Patient: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street

_____
City State Zip Code

INSURANCE INFORMATION

Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____

_____

SECONDARY INSURANCE, if applicable

Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____

DENTAL INFORMATION

When was your last dental appointment? _____ Reason for appointment? _____

What concerns do you have in your mouth today? _____

Have you ever been told you have or treated for periodontal disease? _____

Have you ever had complications following a dental experience? _____ If yes, please explain.

_____

Whom may we thank for referring you to our practice? _____

MEDICAL INFORMATION

Emergency Contact_____Phone_____

Family Physician _____ Phone _____

Are you under the care of a physician? ☐ **Yes** ☐ **No**

If yes, for what? (be specific) _____

When was your last physical? _____

Have you ever had a serious illness or major surgery? _____

Have you ever been advised to be pre-medicated prior to dental treatment? _____

Have you ever used a bisphosphonate drug for osteoporosis or cancer treatment (i.e. Fosamax, Aredia or Zometa)? ☐ **Yes** ☐ **No**

Women- Do you suspect that you are pregnant? ☐ **Yes** ☐ **No** **Are you nursing?** ☐ **Yes** ☐ **No**

Have you ever had any of the following? (check all boxes that apply):

☐ Angina & Carries Nitroglycerine*
☐ Heart Disease*
☐ Blood Thinners (Coumadin)*
☐ Low Blood Pressure with Fainting
☐ Heart Murmur
☐ Mitral Valve Prolapse W/Regurgitation
☐ Artificial Heart Valve or Joints
☐ Rheumatic Heart Disease
☐ Stroke
☐ Blood Disease/ Bleeding Disorder
☐ High Blood Pressure *
☐ Anemia/ Leukemia
☐ Arthritis
☐ Asthma from Anxiety & Carries Nebulizer*

☐ Allergies to Latex*
☐ Metal (Nickel) Allergies*
☐ Allergy to Amoxicillin / Penicillin/Sulfa*
☐ Allergies to Anesthetics*
☐ Hepatitis Type _____
☐ Liver Disease
☐ Tuberculosis
☐ Respiratory Disease
☐ MS
☐ Diabetes Type_____*
☐ Epilepsy / Seizure Disorder*
☐ Cancer
☐ Radiation Treatment
☐ Taken PhenFen or Redux

☐ Mental Health Care
☐ Use/d Recreational Drugs
☐ Chemical Dependency
☐ Special Diet
☐ Nervous Problems
☐ A I D S/ HIV
☐ Fainting/ Dizzy Spells
☐ Sinus Problems
☐ Migraines/ Neck Aches
☐ Ulcer
☐ Venereal Disease
☐ TMJ/ Painful Jaw Joint
☐ Swollen Neck Glands
☐ Use Tobacco/ Smoking

Is there anything else we should know about your medical history?
_____
_____

Are you allergic to anything else not listed above? _____

Please list any medications you are taking and the purpose.
_____
_____
_____

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CONSENT FOR SERVICES AND TREATMENT

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits which I am entitled. I will not hold my dentist or any of her staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize the administration of such medications and performances of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____

Print Patient's Name

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of patient, parent or guardian

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PAYMENT & FINANCIAL POLICIES

We are committed to providing you with the best possible dental care. *The patient or parent signing the financial agreement is established as the account holder for the family.* The account holder is not necessarily the insurance subscriber. The account holder accepts full responsibility for payment of all charges, including instances in which a divorce decree specifies shared responsibilities.

If you have dental insurance, we look forward to helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We are participating providers with Delta Dental Premier Plans, Health Partners open access and the Premier Network, which includes several different plans. Please remember that assisting you in the filling of insurance claims is a courtesy to you and all charges become your responsibility on the date services are rendered.

Payment is due at the time services are rendered. Budgeted contractual arrangements may be made in advance of treatment in case of extensive treatment needs. We accept cash, personal checks, Visa, MasterCard and Discover. Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of 1 ½ % per month. Charges will also be made for broken appointments and appointments cancelled within 24-hour advance notice.

We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

We are here to serve your family's dental needs optimally, and to make the entire process a pleasant experience for all involved.

I HAVE READ, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY AS STATED ABOVE

_____

Patient's Name

_____ _____

Signature of Responsible Party **Date**

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PLATT DENTISTRY, P.A.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Mackenzie Platt, D.D.S.

Telephone: 952.469.4588 Fax: 952.469.3370

Address: 11183 205th Street West Lakeville, MN 55044

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

CONSENT: PATIENT/GUARDIAN

I, _____, have had full opportunity to read and consider the contents of this Consent
(please print)

form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Guardian Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

HIPAA PRIVATE POLICY EFFECTIVE SEPTEMBER 23, 2013