BLUE SPRUCE DENTAL

Kevin R. Timm, DDS

Child's Medical and Dental Information

Dentistry has changed significantly in the last few years and these new technologies require more information to treat you safely and completely. The following is important information about your child's physical and dental health as well as some questions about lifestyle. Your honest and complete answers allow us to serve you to the best of our ability.

Name______________________ Birthdate__________ Social Security #______________

Mom's Name ______________________ Dad's Name ______________________

SS # ______________________ SS # ______________________

Address ______________________ Address ______________________

City, State, Zip______________________ City, State, Zip ______________________

Home # __________ Work # __________ Home # __________ Work # __________

Cell # __________ DL # __________ Cell # __________ DL # __________

Email: ______________________ Email: ______________________

Emergency Contact ______________________ Phone # ______________

Whom may we thank for referring you to our office: ______________________

General Health Information

Physicians Name______________________ City______________ Phone______________

Last Physical Exam______________________ Rate health Good / Fair / Poor

Is your child taking any medications or drugs (including Aspirin) YES / NO

Name of Medicine	Dosage	Times per day	Purpose

Allergies to: ____

Has your child ever been Premedicated for dental treatment? YES / NO Reason ______________

Do you have any of the following? Check all that apply….

	Cancer		Neurological disorders		Rheumatic Fever		Measles
	Heart Murmur		Radiation/Chemotherapy		Diabetes		Mumps
	Heart Problems		Blood Transfusion		Kidney/Liver issue		Chicken Pox
	Asthma		Handicaps/disabilities		Hepatitis		Tuberculosis
	Epilepsy		Frequent headaches		AIDS/HIV		

Any disease, condition or problem not listed:______________________________

(OVER)

DENTAL INFORMATION

Name of Previous Dentist_________________________City______________Phone#________________

Date of Last Exam__________________Purpose____

What did you like **best** about your previous Dentist?__________________________________

What did you like **least** about your previous Dentist?_________________________________

Are you aware of any dental problems? YES / NO Explain___________________________________

Date of last Bitewing Xrays:_________________Date of last Full Series or Panorex?_______________

Has your child ever had Braces? YES / NO Orthodontist Name________________________________

Has your child ever used Nitrous Oxide? YES / NO How did they like it?_____________________

Do they drink Pop or Sports Drinks? YES / NO Juice? YES / NO Amount per day____________

Do they or have they ever used tobacco products? YES / NO Type?___________ Amount?_________

Would your child be interested in whitening their teeth? YES / NO

Do they ever have a popping or clicking in their jaw? YES / NO

What would you consider your child's pain threshold to be: LOW AVERAGE HIGH

How nervous or worked up do they get during dental appointment? ____________________________

Please rate the health of their mouth 1-10 (10 being best)_________What do you want it to be?______

What would you like to change about your child's smile?

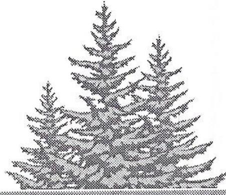
Do you have any other comments or concerns we should know about?

Is there any other person who may bring child to appointments and have authority to approve treatment (please indicate relationship)? ____

____

I understand that in order to receive the best care, I must do my part to help the doctor and answer these questions to the best of my ability. I certify that the above information is complete and accurate. If I have dental insurance, I realize that the full bill is my responsibility and authorize Dr. Timm to work as my agent to assist me in receiving payment from the insurance company.

Parent Signature____Date__________________



Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment. *Please sign this form below to acknowledge that you have today either received or reviewed a copy of our notice of privacy practices.*

PATIENT ACKNOWLEDGEMENT

I acknowledge I received a copy or have been given the opportunity to receive a copy of The Notice of Privacy Practices.

Name: ____________________ **Signature:** ____________________ **Date:** ____________

I am also signing for my minor children: ________________________________

Please print the name(s) of your Children under the age of 18

PATIENT CONSENT

I consent to your disclosures of my information, which you deem are necessary in connection with providing proper treatment.

Name: ____________________ **Signature:** ____________________ **Date:** ____________

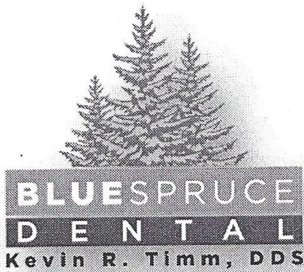
I am also signing for my minor children: ________________________________

Please print the name(s) of your Children under the age of 18

I also give consent to talk about treatment, appointments, and insurance/financial arrangements with the following individuals: (e.g. spouse, parent, adult child, care giver):

____

Please print all names



FINANCIAL POLICY

Thank you for choosing Kevin R. Timm, DDS - Blue Spruce Dental for your dental needs. It is our goal for our patients to understand their treatment needs as well as their financial responsibly before treatment begins. It is our desire to make dental treatment affordable to all of our patients. Please review the following policies and procedures:

PAYMENT POLICY: Payment for services is required at the time service is provided. If you have dental insurance, your estimated co-pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.

1) We accept Cash, Checks, Money Orders, Visa, MasterCard, Discover and American Express.
2) We offer a **5% courtesy adjustment** for all services over $1000 that is paid in full prior to the appointment date by cash or check. (Not applicable when applying any insurance coverage)
3) Extended payment plans are available through Care Credit with prior approval.
4) A service charge of 2% per month (24% APR) will be added to any account that has an outstanding balance of 60 days or greater.
5) You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees, court fees and/or attorney fees.
6) Fees will apply for any check that is returned by the bank ($30 fee).
7) In the event of an emergency after regular business hours an emergency fee ($80 fee) will be charged in addition to the necessary treatment fees.
8) MINOR PATIENTS: The adult accompanying a minor and the parents (or guardians) are responsible for full payment, regardless of court child support order. For unaccompanied minors, non-emergency treatment will not be done unless prior approval and financial arrangements have been made.

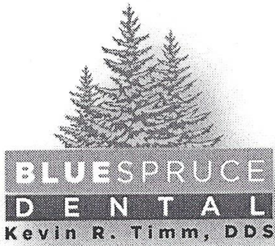
DENTAL INSURANCE: As a courtesy we will gladly ☺ file your claims and accept assignment of dental insurance benefits provided you agree to the following:

1) Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
2) Insurance coverage will never completely pay for all of your dental care. It is only meant to assist you.
3) We currently accept most insurance plans. This means that we work with **literally hundreds of companies.** Although we maintain computerized histories of payment by a given company, **they do change**, therefore it is **NOT possible** to give you a guaranteed quote at the time of service.
4) We estimate your portion based on the most up-to-date information we have, it is **ONLY AN ESTIMATE**. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
5) If your insurance does not pay within 60 days, **Blue Spruce Dental** reserves the right to request payment from you, in full, for services provided and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contact between **YOU** and **your insurance company**. Our office is not, and cannot be part of that legal contract. **Ultimately, you are responsible for all charges incurred in our office.**
6) Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees. All insurance companies have maximum payments each benefit year.
7) There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us and CANNOT guarantee the total amount of your "out of pocket" expenses.
8) We do not base our treatment recommendations on what the insurance company will cover but rather what is the **best treatment for you and your dental health.** ☺

I have read and understand the above Financial Policy.

X______________________________ X______________________________ ______________________

(Patient or Parent or Guardian Signature) *(Print Patient Name)* *(Date)*



APPOINTMENT POLICY

Thank you for choosing Kevin R. Timm, DDS - Blue Spruce Dental for your dental needs. We are committed to delivering quality, urgent and comprehensive dental care. We greatly value our scheduled patients as they allow us to provide quality care in a timely matter.

Welcome! We know your time is valuable and we respect that! ☺ In fact, we make it a point to schedule all our patients with this in mind. Our daily goal is to seat all of our patients on time. In an effort to provide timely services to our patients we never over-book our schedule like so many other health care facilities. This makes our time very valuable to us as well. Therefore, in an effort to avoid broken appointments and late patient arrivals, the following policy has been adopted.

Appointments/Confirmations:

1) When an appointment is scheduled, we ensure that our professional staff is reserved for you and an operatory is prepared for your specific appointment requirements.
2) Your acceptance of a scheduled appointment serves as a contract for services with Blue Spruce Dental.
3) As a courtesy, we will text, email, and/or call you in advance of your appointment and to ensure we are prepared to make your experience as pleasant as possible
4) Appointments **must be confirmed within 48 hours of the appointment time** by responding to our confirmation text, email, or call.
5) If you miss our confirmation text, email, or call and need a different appointment time, please contact us as soon as possible to confirm or reschedule based upon current appointment availability.
6) If you must change your appointment**, we require at least 48 hours notice**. We prefer that you call during our office hours so we can help reschedule your appointment at a time that works for you.
7) Please **arrive on time or early** for your scheduled appointment. We may be unable to hold your reserved time if you are more than 10 minutes late.

Broken / Missed Appointments:

1) **Cancellations made with less than 48 hours notice will be charged a $50 fee**.
2) **If you do not cancel your appointment with at least 48 hours notice or do not come in for your scheduled appointment,** we will consider this to be a broken / missed appointment. Notations will be placed in your patient record to indicate that an appointment has been broken.
3) Patients may be charged a **broken appointment fee of $50** after the first broken appointment. A letter will be sent to the patient reminding them of our appointment policy.
4) Future appointments will not be rescheduled until the broken / missed appointment fee has been paid.
5) If you have multiple broken appointments, our office reserves the right to not reschedule any subsequent appointments with you OR may place you on a Quick Call List – which allow us to check your availability when we have time in our schedule. In addition, in extreme circumstances of multiple broken appointments the patient will need to provide upfront payment to their account for the value of the appointment, which will not be refundable, if the appointment is missed.

Appointment Delays:

We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an emergency or a complication in a scheduled procedure. **Please accept our apology in advance** should this occur during your appointment. We will provide you with the same courtesy if you are in need of emergency treatment. If you are waiting more than 15 minutes, please ask our Front Desk Team the estimated length of delay.

We hope by presenting our Appointment Policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your Dental Care!

I have read and understand the above Appointment Policy.

X____________________________ X____________________________ ____________________

(Patient or Parent or Guardian Signature) *(Print Patient Name)* *(Date)*