MAPLE BROOK DENTAL CENTER OF MN, LTD.

ABOUT YOU

Today's Date: _____

Name: _____
Last First MI

I prefer to be called: _____ ☐ Male ☐ Female

Birth date: ____/_____/_____ Age: _____

Social Security #: _____

Home Address: _____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Phone Number at Home: _____

Phone Number at Work: _____

Cell Phone Number: _____

E-Mail Address: _____

EMPLOYER: _____

Employer's Address: _____

_____
City State Zip

Occupation: _____

STUDENTS

Name of School: _____

School Address: _____
City State Zip

SPOUSE'S NAME: _____

Spouse's Employer: _____

Phone Number at Work: _____

Spouse's Birth date: _____

Previous Dentist: _____

Date of Last Dental Visit: _____

Did they do x-rays? ☐ Yes ☐ No

EMERGENCY CONTACT: _____

Relationship: _____ Phone: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Company: _____

Policy #: _____

Group #: _____

Insured's Name: _____

Relationship: _____

Insured's Birthday: _____/_____/_____

Social Security #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Company: _____

Policy #: _____

Group #: _____

Insured's Name: _____

Relationship: _____

Insured's Birthday: _____/_____/_____

Social Security #: _____

Insured's Employer: _____

Person Responsible for Account:

_____

Home#: _____

Work#: _____

Billing Address: _____

_____
City State Zip

Our practice is driven by our continued,
Good relationships with current patients.

We appreciate and value each and every one.

Who may we thank for referring you to our office?

_____

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MEDICAL HISTORY

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone #: _____

Date of Last Visit: _____

Your current physical health is:
☐ Good ☐ Fair ☐ Poor

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

If so, please explain: _____

_____

Are you taking any prescription drugs? ☐ No ☐ Yes

If yes, please list medications:

_____

_____

Do you now, or have you ever smoked? ☐ No ☐ Yes
(cigarettes, pipe, cigar)

Do you chew tobacco? ☐ No ☐ Yes

For Women:

Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

Have you ever had any of the following diseases or medical problems? (Please circle, if yes)

Heart attack / stroke	Psychiatric Care
Cancer / Chemotherapy	Epilepsy / Seizures
Heart Murmur	Diabetes Tuberculosis (TB)
Rheumatic Fever	Drug / Alcohol Abuse
HIV+ / Aids	Venereal Disease
Heart Surgery / Pacemaker	Hemophilia
Mitral Valve Prolapse	Abnormal Bleeding
Congenital Heart Defect	Kidney Problems
Anemia / Radiation Treatment	Fainting Spells
Artificial Valves	Difficulty Breathing
Sinus Problems	Hospitalizations
High / Low Blood Pressure	Hepatitis
Blood Transfusions	Ulcers / Colitis\
Severe / Frequent Headaches	Emphysema / Glaucoma

DENTAL HISTORY

Please tell us why you are visiting us today:

_____

_____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work?
☐ No ☐ Yes

Have you ever had treatment for, or been diagnosed with periodontal or gum disease?
☐ No ☐ Yes

Do you now or have you ever experienced pain and/or discomfort in your jaw joint (TMJ / TMD)?
☐ No ☐ Yes

Your current dental health is:
☐ Good ☐ Fair ☐ Poor

Are you happy with your smile? ☐ No ☐ Yes

How many times weekly do you floss? _____

How many times a day do you brush? _____

Are you allergic to any of the following drugs?

(If yes, please circle)

Penicillin	Tetracycline
Aspirin	Dental anesthetics
Erythromycin	Codeine
Latex	Other (please list below)

_____

_____

Please list any serious medical problems or conditions you have ever had:

_____

_____

Payment is due in full at time of treatment unless prior arrangements have been approved by our Business Administrator.

Please see the attached Financial Disclosure.

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff, with my informed consent, to perform any necessary dental services needed during diagnosis and treatment.

_____ _____

Signature **Date**

MAPLE BROOK DENTAL CENTER of MN, LTD.

8421 West Broadway
Brooklyn Park, MN 55445
(763) 424-5313

FINANCIAL DISCLOSURE

Dr. Lam and staff would like to thank you for choosing our team to serve your dental needs. Our team is committed to providing you with the highest quality of care in a family-based, high-technology practice. We value the confidence you have placed in us and will strive to build on that confidence as we develop our long-lasting patient relationship.

Our treatment fees are demographically competitive and directly reflect the quality of care we feel you deserve. Your treatment and its cost will be fully discussed with you prior to scheduling an appointment. We encourage you to ask questions regarding both your treatment and its cost in addition to payment options.

If you have insurance, the following information may be helpful.

- Insurance is designed to help offset the cost of your dental care and may not cover the entire procedure.
- **Your insurance co-pay is due on the day of service.**
- It is to your responsibility to contact your insurance company if you have questions regarding your benefits.
- Insurance estimates are just that. They are estimates. They are not a guarantee from your insurance company of payment and are used only to assist you in determining your approximate out of pocket expenses.
- Your insurance benefits have been determined in a contract between your employer and your employer's insurance company. Maple Brook Dental Center is not involved in your benefit decision process or agreement.
- Fee estimates are valid for 60 days from the date of origin and may be altered as your dental needs change.

The following applies to all patients whether or not insured:
All fees and account balances over 60 days are the patient's responsibility.

I understand:

In the event my account is sent to a collection agency, I will be obligated to pay all costs of collections, including but not limited to, any reasonable attorney's fees.

Maple Brook Dental Center reserves the right to charge $50 for a failed appointment and I understand my account may be inactivated.

My signature below assures Maple Brook Dental Center I have read and agree to the above.

PATIENT: _____ DATE: _____

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FINANCIAL POLICIES

At Maple Brook Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of patients. Some of you have dental benefits but some of you carry no insurance. If you have dental benefits.....Congratulations! You are very fortunate. Here are some items that may be helpful to you.....

We estimate your portion based on the most up-to-date information we have, but it is only an estimate.

We bill your insurance as a courtesy to you. If your insurance company has not paid after 60 days, Maple Brook Dental will request payment in full. It will be your responsibility to collect the funds due you from your insurance company. This is a rare occurrence, but it is important you recognize the insurance you have is a legal contract between YOU and YOUR INSURANCE COMPANY. Your dental benefits are based upon a contract made between your **employer and your insurance company**. Our office is NOT, and CANNOT be a part of the legal contract. Ultimately, you are responsible for all charges incurred in our office. Finance charges will begin to accrue when an account becomes 90 days past due.

If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans seldom pay for the completion of your dental care. It is only meant to assist you in payment.

Broken Appointments: A specific amount of time is reserved especially for your care and we strongly encourage all patients to keep their appointments. When you find you must change your appointment, we require at least 24-hour notice (emergencies are an exception). We will do our best to confirm appointments 1-2 days in advance, but keeping an appointment is the patient's responsibility. We reserve the right to charge $50 for a failed appointment.

Effective, January 1, 2007

Maple Brook Dental will request payment on day of service. This may be your full **portion** of the fee, or in the case of those without insurance, we will request the full amount be paid on the day of service. We accept MasterCard, Visa, Discover, cash and checks. If you are in need of an extended finance option, we also have available Care Credit Finance. This company offers a 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your needs on approved credit. We will be happy to assist you with your application.

We welcome new patients to our family and celebrate our long relationships with existing patients. We look forward to helping you get the healthy, beautiful smile you have always wanted, and encourage you to let us know if there is anything we might do to make your visits here more pleasant.

Dr. Dan Lam and Staff

MAPLE BROOK DENTAL CENTER OF MN, LTD.

PATIENT HIPPA AWARENESS

With My permission, Maple Brook Dental Center may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to the Maple Brook Dental Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the rights to review the Notice of Privacy Practices prior to signing this consent. Maple Brook Dental Center reserves the rights to revise its Notice of Privacy at any time. A revised Notice of Privacy may be obtained by forwarding a written request to the office.

With my permission, the office of Maple Brook Dental Center may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out my dental care, such as appointment reminders, insurance items pertaining to my dental care.

With my permission, the office of Maple Brook Dental Center may mail to my home or other designated location any items that I assist the practice in carrying out my dental care, such as appointment reminder cards and patient statement.

By signing this form, I am allowing Maple Brook Dental Center to use and disclose my protected health information disclosure in reliance upon my prior consent.

Signature of Patient or Legal Guardian
Printed name of Patient or Legal Guardian
Today's date