IMAGINE SMILES

MINOR/CHILD PATIENT INFORMATION FORM

Patient's First Name _____ M.I. _____ Last Name _____

Name patient prefers to be called _____ Date of Birth _____ / _____ / _____

Social Security # _____ - _____ - _____ E-Mail Address _____

With whom does the minor reside (please circle)? Both parents Mother Father Guardian Other

Father's Information

First Name _____ M.I. _____ Last Name _____

Home Address _____ Apt. / Suite _____

City _____ State _____ Zip _____

Home Phone# ( ) _____ Cell# ( ) _____ Work# ( ) _____

SSN _____ - ____ - _____ DOB _____ / ____ / _____ E-Mail _____

Mother's Information

First Name _____ M.I. _____ Last Name _____

Home Address _____ Apt. / Suite _____

City _____ State _____ Zip _____

Home Phone# ( ) _____ Cell# ( ) _____ Work# ( ) _____

SSN _____ - ____ - _____ DOB _____ / ____ / _____ E-Mail _____

***we ask for a cell number and email to maximize communication with our patients. This info will not be released to any 3rd parties.**

Primary Dental Insurance Provider _____

Employer Name _____ Subscriber ID#_____ Group#_____

Policyholder Name _____ SSN ____ / ___ / _____ DOB _____ / ___ / _____

Relationship to patient (please circle) Self Spouse Parent/Guardian other (specify) _____

Telephone#( ) _____ Name of benefits coordinator _____

Secondary Dental Insurance Provider _____

Employer Name _____ Subscriber ID#_____ Group#_____

Policyholder Name _____ SSN ____ / ____ / _____ DOB _____ / ___ / _____

Relationship to patient (please circle) Self Spouse Parent/Guardian other (specify) _____

Telephone#( ) _____ Name of benefits coordinator _____

How did you find us ☐ Google/web search ☐ online review ☐ family member ☐ friend ☐ other

If referred by an individual, whom can we thank for referring you? _____

I confirm that the above information is complete and accurate to the best of my knowledge

_____ _____

Signature *Date*

IMAGINE SMILES

Health History Form

Patient name _____ Today's Date _____

Primary Physician _____ Phone# ( ) _____

Clinic Name _____ City _____ State _____

Is patient currently receiving continual care from a physician/MD? _____

Why _____

_____

Known Drug allergies, (Penicillin, codeine, etc)_____

Is patient currently taking **blood thinners or osteoporosis medications**? ☐ Yes ☐ No

If yes, medication name and dose _____

Has the patient ever had complications or prolonged bleeding following surgery? ☐ Yes ☐ No

Is patient allergic to any metals or jewelry?_____

Has patient had any unusual reaction to local anesthesia? Yes ___ No ___

If yes, please explain _____

Please check any of the following, which the patient may have had or currently has:

__ Osteoporosis
__ Artificial Joints*
__ Anemia
__ Blood Disorders
__ Hepatitis A, B or C
__ Kidney or Liver Disease
__ AIDS or HIV
__ High Blood Pressure
__ Low Blood Pressure
__ Stroke
__ Cancer
__ Head or Neck Radiation
__ Chemotherapy
__ Leukemia
__ Tumors / Growths

__ Heart Attack / Failure
__ Mitral Valve Prolapse
__ Heart Disease / Angina
__ Artificial Heart Valve*
__ Pacemaker / ID
__ Drug / Alcohol dependency
__ Physical / Mental Handicap
__ Infectious Endocarditis*
__ Congenital Heart Defect*
__ Heart Transplant
__ Arthritis/Gout
__ Ulcers
__ Recent weight loss
__ Diabetes
__ Chemical Dependency

__ Canker Sores
__ Cold Sores
__ Tobacco Use
__ Herpes Infections
__ Sinus problems
__ Lung Disease
__ Tuberculosis
__ Breathing Problems
__ Asthma
__ Seasonal Allergies
__ Sinus / Hay Fever
__ Emphysema
__ Rheumatic fever
__ Glaucoma
__ Epilepsy / Seizures

**** history of these indicates that antibiotic premed may be needed for dental care***

Any other conditions not listed above _____

_____

(FORM CONTINUES ON OPPOSITE SIDE)

IMAGINE SMILES

Medications

Please list any medication you are currently taking. If you have a pre-written list, DO NOT fill out this part of the form. Please provide this list to the front desk and we will make a digital copy and place in your record

Medication Name	Dose (mg)	How often/day			
_____	_____	1	2	3	4
_____	_____	1	2	3	4
_____	_____	1	2	3	4
_____	_____	1	2	3	4
_____	_____	1	2	3	4

Women: are you

__ Pregnant __ Planning on Pregnancy __ Nursing __ Taking birth control

Dental History

Approximate date of last dental visit _____ Reason _____

What is the reason for your visit today_____

_____

Please indicate if you are experiencing any of the following conditions:

__ Bleeding gums
__ Color/shape of teeth
__ Brushing habits
__ Toothache
__ Broken tooth
__Mouth odor
__Sensitivity to hot/cold
__Dry mouth
__Pain in/around ears
__Sensitivity to sweets
__Flossing
__Lip/mouth ulcers
__Sensitivity when chewing
__Loose teeth

Tell us what it is about your smile that you don't like _____

_____

_____

If you could change anything about your smile, what would it be?_____

_____

_____

Patient or Parent/Guardian Signature _____ Date _____ / ____ / _____

IMAGINE SMILES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: DOUGLAS GREEN DDS.

Telephone: (763) 269-8650 Fax: (763) 269-8654

Address: 10705 Town Square Drive NE,
Suite 200
Blaine, MN 55449

Patient's Name (please print): _____

Patient (or parent/guardian) Signature: _____

Date: _____ / _____ / _____

IMAGINE SMILES

PATIENT COMMUNICATION FORM

Family and Friends

It is an Imagine Smiles policy that we do not release confidential medical information regarding your treatment to family members or friends, except for the following:

1) parent or legal guardian
2) other persons authorized by the patient
3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the treatment room, we will assume, unless you object, that this person is allowed to receive information regarding your treatment
4) in emergency situations
5) as otherwise permitted by the Health Insurance Portability & Accountability Act of 1996.

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/ babysitters, etc. please indicate this information below so that we may best serve you. If you do not want any of your medical information provided to a family member, please circle the "no" response. By signing below, you authorize the listed individuals to receive information regarding your treatment or care at any time.

If you choose to add or remove names at a later date, please confirm any changes to our staff, in writing, so that we may add this to your patient chart. You may also choose to cancel this authorization to the extent allowed by law. If you choose this option, you do so with the understanding that the Imagine Smiles doctors and staff may have already released information about you after you had initially given permission. You understand that canceling this authorization would not prohibit any release of information by the practice in reliance on your original authorization.

	Health care info		Financial info	
Spouse: _____	Yes	No	Yes	No
Parent: _____	Yes	No	Yes	No
Other: _____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No

Alternative Communications

You are also entitled to specify alternative, reasonable means of communication. If you do not wish to be contacted in a certain way, please indicate these desires below:

☐ Cell phone ☐ Home phone ☐ Work phone ☐ Text message ☐ Email

Patient name (please print): _____

Patient/Parent/Guardian signature: _____ Date: _____

FOR OFFICE USE ONLY

Changes to the above

	(please circle one)		Date	Initial
Name: _____	Please add	Please remove	_____	_____
_____	Please add	Please remove	_____	_____
_____	Please add	Please remove	_____	_____
_____	Please add	Please remove	_____	_____

IMAGINE SMILES

Patient Financial Policy

At Imagine Smiles our primary goal is to care for your dental needs. We consider dental care to be the #1 investment an individual can make towards their overall health and it is our desire to provide you with exceptional care at an affordable price. But like any other business we have bills that are associated with the care we provide you. As a result, we expect all individuals to pay for services or products on the day which they were received. We do realize that every individual has different financial abilities. If full payment cannot be made on the day of service, we offer several different payment options that will allow you to obtain the dental care you deserve.

Payment on Day of Service* - we offer a 5% discount to patients who pay their bill on the day of service.

Payment in Advance of Service* - Because it minimizes our accounting expense, we offer a 7% discount for patients who pay for their treatment on the date the appointment is made.

Discount for Seniors* - we offer an additional 5% discount for patients age 65 or older.

Dental Insurance - Many patients have third party dental insurance provided by their employer. As a courtesy, we will electronically file all dental insurance claims for you, but be aware that there are over 50,000 unique dental plans in existence nationwide today, and they change constantly. Since dental insurance only covers a percentage of most services, predicting the exact cost to you can sometimes be difficult. We do our best to interpret the specifics of the insurance companies we work with but we cannot know the minute details of each and every dental plan at all times. We do expect patients to pay any non-covered portion of services rendered on the respective date of service. Any overpayments by you will be applied as a credit to your account for future services or products. To avoid overpayments, we recommend that you review the specifics of your plan to avoid any unnecessary or unplanned expenses.

Minnesota Care Tax - The state of Minnesota enforces a 2% care tax for health care providers. This is designed to help fund the costs of state-run health care programs. Dental providers are assessed this tax for all services they provide. Please note that this tax is included in the fee we charge for all services.

Grace Period - On the rare occasion that patients forget to bring a form of payment to their appointment, we do allow a 30 day grace period after the day of treatment to satisfy this debt. If the balance is not paid in full by the end of this 30 day period, any outstanding balance will accrue at a rate of 1.5% per month (18% annually). Failure to settle a balance for more than 90 days may result in the patient account being turned over to a collections agency.

Patient Financing - With larger treatment plans patients have the option to amortize the cost of their treatments using an outside financing entity. To help these patients we offer financing through Lending Club & CareCredit. Both are reputable companies with positive track records in the dental industry. Please be aware that minimum down payments are often required. Also, due to financing charges to us, we cannot extend payment discounts when these third party services are utilized.

Quotes For Treatment - We often quote prices for our services. These will be honored as long as treatment is initiated within 30 days of a quote.

I understand the financial policies that have been described in this form. I acknowledge that insurance coverage for myself, or any dependents, is between myself and my insurance provider. I agree that any charges not covered by insurance will be my sole responsibility.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

* Due to rules surrounding the participation in all dental insurance plans, payment discounts are not available for patients who ask us to submit to a third party provider for partial reimbursement for services.

IMAGINE SMILES

PHOTO AND TESTIMONIAL RELEASE FORM

I hereby grant permission to Imagine Smiles to use my photograph(s) and any testimonial(s) I give regarding the dental care I receive from Imagine Smiles, in any marketing, advertising or teaching materials, including use on the Imagine Smiles website or social media accounts (Facebook, Twitter, Pinterest, Youtube, etc.). I acknowledge Imagine Smiles' right to crop, adjust or edit my photograph(s) at their discretion. I acknowledge that Imagine Smiles may choose not to use my photograph(s) and testimonial(s) at this time, but may do so at their discretion at a later date. I also understand that once my image(s) or testimonial(s) is digitally published by Imagine Smiles, said image(s) can be downloaded by any computer user, which is beyond the control of Imagine Smiles, and I agree to hold Imagine Smiles, their doctors & staff members, and any other affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of my photograph(s) and testimonial(s) as stated above until I revoke this consent in writing.

Patient Name _____

Signature _____ Date _____ / ____ / _____

Printed Name of Parent/Guardian (if patient is under age 18) _____

Signature of Parent/Guardian Signature _____

To revoke this consent at any time, please submit a written request to:
Imagine Smiles - 10705 Town Square Drive NE, Ste 200, Blaine, MN 55449