Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions

Child's Information

Child's Name (First and Last) _____ Nickname _____

Date of Birth _____ Age _____ Gender _____ SS# _____

School _____ Grade _____

Home Address _____

(Street) (City) (Zip)

Mother Stepmother Guardian Other (Please specify)

Name _____

Home Phone _____ Work Phone _____

Date of Birth _____

Employer _____

Occupation _____ How Long Held? _____

Social Security # _____ Email Address _____

Father Stepfather Guardian Other (Please specify)

Name _____

Home Phone _____ Work Phone _____

Date of Birth _____

Employer _____

Occupation _____ How Long Held? _____

Social Security # _____ Email Address _____

Parent's Marital Status: ○ Married ○ Domestic Partnership ○ Separated ○ Divorced ○ Single ○ Widowed

*Responsible Party (if different from parents)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Date of Birth _____

Employer _____

Occupation _____ How Long Held? _____

Social Security # _____ Email Address _____

Who may we thank for this referral?

Family or Friend _____ General Dentist _____ Pediatrician _____

Internet _____ Other (Please specify) _____

Primary Dental Insurance

Subscriber's Name _____ Relationship to Patient _____

Date of Birth _____ Social Security or ID Number _____

Employer _____

Insurance Company _____ Group # _____

Additional Insurance:

Subscriber's Name _____ Relationship to Patient _____

Date of Birth _____ Social Security or ID Number _____

Employer _____

Insurance Company _____ Group # _____

James L. Bialk, D.D.S., S.C. 121 Wolf Run, Ste. 3, Mukwonago, WI 53149 (262)363-4016

We would like to welcome you, your family, and friends to our practice. Our practice continues to grow with referrals from our patients. We strive to meet the goals and needs of all our patients and encourage any questions you may have regarding our fees, treatments, insurance and financial policy. In order for us to better serve you, we need all patients to complete our information and insurance forms before being treated.

PATIENTS WITHOUT INSURANCE: Full payment is due at the time of services, unless previous arrangements have been made. Senior Citizens (65 and up) receive a 10% senior courtesy on all procedures when paid in full at time of service. Anyone who pays in full at time of service by cash or check will receive a 5% discount. Our office accepts cash, checks, MasterCard and Visa.

INSURANCE: As a service to you, we will submit all insurance claims to your insurance company. Your insurance is a contract between you and your insurance company, we are not a party to that contact. Insurance questions should be directed towards your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc… We reserve the right not to become involved in any disputes regarding insurance payments. After your insurance has paid their portion of the charges, the patients portion, or co-payments, must be paid in full within 30 days.

Account balances over 30 days are subject to finance charges of 1.5% per month.

CHILDREN: In case of divorce or separation where the child's parent who has dental insurance is not present, the parent seeking treatment is responsible for the full amount that day. We will assist the parent in filling out dental insurance forms for reimbursement from the policy holder's insurance. Divorce decrees are so varied in who is responsible for what, that we cannot do split billings.

MISSED APPOINTMENTS: Unless canceled at least 24 hours in advance, our policy is to charge a full charge of $12.50 per 15-minute time slot. Please help us serve you better by keeping scheduled appointments.

RELEASE OF DENTAL INFORMATION AND X-RAYS: Our office requires a release form to be signed before any information or x-rays are given out. There is a charge for duplicating x-rays.

We reserve the right to contact our collection attorney for services not paid within 60 days from the date of service.

Thank you for reading and understanding our financial policy, please let us know if you have any questions or concerns.

I have read the FINANCIAL POLICY. I understand and agree to this policy,

SIGNATURE _____ DATE _____

JAMES L. BIALK, D.D.S., S.C.
121 Wolf Run
Mukwonago, WI 53149
(262) 363-4016

Acknowledgement of Receipt of Privacy Notice

PATIENT NAME (please print) _____ Date of Birth _____

Your privacy and the privacy of your protected health information is important to us. To provide you with health care, we must share your protected health information. It will be used for treatment, payment and our health care operations.

Our Notice of Privacy Practice ("NPP") gives you information about how we may use and disclose your protected health information. You have the right to review our NPP before signing this Acknowledgement.

Our privacy practices may change over time. If we change our NPP, we will provide you with a new copy the next time you receive care.

I have read the above.

Patient or Patient's Representative: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Dental History

What would you like us to do for your child today? _____

Previous Dentist _____ Date of last dental care _____

May we contact your previous dentist to get copies of your child's previous dental records? ○ Yes ○ No

Has your child ever experienced a mouth or chin injury? ○ Yes ○ No

Please check all that apply: ○ Speech Difficulty ○ Thumb/Pacifier Habit ○ Jaw Pain ○ Grinds Teeth

*Other (Please specify) _____

Has your child ever experienced an adverse reaction during a dental/medical procedure? ○ Yes ○ No

* (If yes, please explain) _____

Other information about your child's previous treatment _____

Medical History

Please check all that apply:

- ○ Abnormal Bleeding
- ○ ADD/ADHD
- ○ Aids/HIV
- ○ Anemia
- ○ Asthma
- ○ Autism
- ○ Blood Disease
- ○ Brain Injury
- ○ Cancer
- ○ Chicken Pox
- ○ Convulsions/Epilepsy
- ○ Cough, persistent
- ○ Diabetes
- ○ Digestive Problems
- ○ Down's Syndrome
- ○ Fainting
- ○ Hearing Impaired
- ○ Heart Problems
- ○ Kidney Problems
- ○ Liver Problems
- ○ Respiratory Problems
- ○ Skin Rash
- ○ Special Needs

Additional explanations/comments _____

List medications your child is taking, if any: _____

Food Allergies: _____

Drug Allergies: _____

Material Allergies (ex. Latex): _____

Family Information

Name(s) of Sibling(s)

1: _____ Age _____ Grade _____

2: _____ Age _____ Grade _____

3: _____ Age _____ Grade _____

4: _____ Age _____ Grade _____

*Consent: I hereby authorize that all necessary dental services be rendered for _____

Patient's Name _____

Signature _____ Relationship _____ Date _____

Authorization: I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the dentist to release all information necessary to secure the payment of benefits.

Payment is due in full at time of treatment, unless prior arrangements have been approved. The difference (if any) between amounts paid by your insurance (where there is an assignment of benefits) and the amount billed is your responsibility.

Charges not paid within 90 days may be subjected to a "late payment" fee of 1.5% per month (18% annual percentage rate) until paid in full. Future services may be refused until the amount outstanding is no longer delinquent. Minimum "late payment" fee is 50 cents.

I am aware that there is a $75 missed appointment fee for cancellation without 24 hours' notice.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date