Welcome to Zimbi Dental!!

Will you please help us by providing us with the following confidential information?

Child Name: _____Preferred to be called_____

Date of Birth: _____

PARENT INFORMATION: Who is the responsible party for this child?

Parent's e-mail Address: _____ Last Name: _____ First Name: _____

Preferred to be called: _____ Street Address: _____

City, State, Zip: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

SS#: _____ Driver's License: _____ Sex: M F Married Single

Employer name and address_____

Emergency Contact Name: _____ Phone # : _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____, Place_____ Time: _____

How did you hear about our office? Please check: _____Internet Search ____Patient referral ____Website ____Yellow Pages Other _____

If referred to our office, who may we thank for referring you?_____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____

_____

Secondary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____

(Turn page over)

zimbi DENTAL

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ Date: _____

Patient Date of Birth:_____

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Is your child in good health?
2. Yes No Has there been a change in their health within the last year? Explain: _____
3. Yes No Has your child been hospitalized or had a serious illness in the last 2 years? Explain: _____

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4. Yes No Is your child being treated by a physician now? For what? _____

Name of physician: _____ Date of last Medical Exam: _____

B. HAS YOUR CHILD EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Ringing in ears
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever,
9. Yes No Persistent cough,
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Dizziness
14. Yes No Jaundice
15. Yes No Frequent Headaches
16. Yes No Fainting spells
17. Yes No Blurred Vision
18. Yes No Seizures
19. Yes No Excessive thirst
20. Yes No Joint pain, stiffness

C. DOES YOUR CHILD HAVE OR HAS HAD:

21. Yes No Heart disease
22. Yes No Heart defects,
23. Yes No Heart murmur
24. Yes No Eye disease
25. Yes No Skin disease
26. Yes No TB, emphysema or other lung diseases
27. Yes No Hepatitis, A B C
28. Yes No Kidney, bladder diseases
29. Yes No HIV positive or AIDS-ARC
30. Yes No Tumors, Cancer
31. Yes No Rheumatic fever
32. Yes No Anemia
33. Yes No Stomach problems, ulcers
34. Yes No Thyroid, adrenal diseases
35. Yes No Diabetes
36. Yes No Mitral Valve Prolapse

D. DOES YOUR CHILD HAVE OR HAS HAD:

37. Yes No Surgeries _____
38. Yes No Blood Transfusions _____
39. Yes No Artificial Joint _____
40. Yes No Contact Lenses _____
41. Yes No Psychiatric Care _____
42. Yes No Radiation Treatments
43. Yes No Chemotherapy
44. Yes No Prosthetic heart valve
45: Other: _____
46. Yes No Currently taking Birth Control Pills
47. Yes No Currently Pregnant

F. VITAMINS & MEDICATIONS: _____

_____

_____

ALLERGIES: **LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:**

_____

G. ALL PATIENTS:

48. Yes No Does your child have or had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

49. Yes No Has your child ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

DENTAL HEALTH HISTORY

H. Name of your Child's Former Dentist: _____ How long since they were last seen? _____

Yes No Is this your child's first visit to a Dentist?

Yes No Has your child had any problem(s) with dental treatment in the past?

Yes No Has your child ever received a local anesthetic (novocaine)?

Yes No Has your child ever had fillings and/or sealants?

Yes No Has your child ever worn braces? If so, when? _____

Yes No Does your child snack between meals? What snacks do they prefer? _____

Yes No Does your child drink from a bottle or sippy cup?

Yes No Does your child suck their thumb/finger(s) or uses a pacifier? _____

Yes No How often are you brushing your child's teeth? _____

Yes No How often do you floss their teeth? _____

Yes No Do you have fluoridated water at home?

Yes No Does your child take fluoride supplements daily? If so, what kind and how often?

_____

Yes No Does your child drink at least 2 glasses of water a day?

Yes No Have there been any injuries to teeth, such as a fall, blows, chips, etc?

_____

Yes No Do you have any special concerns about your child's teeth?

_____

Since hereditary is a factor in dental health, how would each parent rate their own teeth? Excellent Good Fair Poor

Yes No Is saving your teeth important to you? If so, why?

_____

Yes No Does having dental treatment make your child afraid or nervous? If yes, what specific things bothers your child?

_____

Please circle the following which are important to you when making your child's dental health decision.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Parent Signature: _____ Date: _____

HIPPA Notice of Privacy Practices
Zimbi Dental

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical, dental, or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, dentist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist/physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (such as Family members, etc.). We will also disclose to a family member, spouse, adult children, any information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to help with your healthcare and/or with payments for your healthcare.
For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example would be when we would need to share your records of information to a specialist or physician to whom you have been referred, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to a dental/hygiene student that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research Criminal Activity, Military Activity

and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your Rights:
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal lay, however, you may not inspect or copy the following records; Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any , of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became affective of **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number 815-444-0000.

Insurance and Financial Policy Agreement

Please read through and initial each paragraph.

INSURANCE: We submit claims to most insurance carriers. Please remember that insurance coverage is a contract between you and your carrier. You, the insured, are responsible for payment on claims that are 1) denied, 2) unpaid due to deductible, 3) paritally paid, or 4) specifically partially paid due to the carrier's arbitrary determination of "usual and customary" rates. All balances are due and payable upon receipt. In-Network Non-Covered Charges: If you have an in-network insurance plan, there may be some services that are considered non-covered based on the insurance company. These non-covered services are Patient Responsibility and will be an out-of-pocket expense.

COLLECTING BALANCES DUE: You agree, in order for us to service your account or to collect monies you may owe, Zimbi Dental may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us.

FINANCIAL POLICY PAYMENT: Fees for routine dental services (examination, cleanings and x-rays) are due in full on the date service is rendered unless pre-arrangements have been made with the Office Manager. The patient assumes co-pays, deductibles, and remaining Patient Responsibility.

MAJOR PROCEDURES: All major work over 1.5 hours, such as crown and bridge, dentures, partial dentures, root canal therapy, root planing, or extensive general dentistry may require a full pre-payment/insurance co-payment to reserve your spot.

MINOR PATIENTS: Parents must accompany minor patients to their appointments. For unaccompanied minors, nonemergency treatment may be denied without proper insurance documentation or payment arrangements.

DELINQUENT ACCOUNTS: Delinquent balances will be forwarded to the collection agency after all reasonable attempts to collect have failed. To remain an active patient, it will be expected that you pay the collection fee incurred and may be required to prepay future appointments to bring your account history in good standing.

CANCELLED OR FAILED APPOINTMENTS: We understand that from time to time emergencies arise which may require that you miss a prescheduled appointment. However, our time, and our other patient's time for needed treatment is valuable. Because we have reserved our time specifically for you, we politely request a 24-hour notification to make changes to an appointment. This allows our office time to attempt to fill the vacancy. A history of last-minute cancellations or failed appointments may result in a down payment to hold your next appointment. Missed appointments, and appointments cancelled within 24 hours of your scheduled appointment, will incur a charge of up to $125 per hour of the scheduled missed appointment. **This amount can be deducted from your pre-paid scheduled appointment.**

COLLECTIONS: If collections become necessary, (collection meaning any balance debt owed to your dental provider not paid within 120 days from treatment unless other financial arrangements have been made), I agree to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I understand and agree that Zimbi Dental may send a collector agent to my residence or work to deliver any necessary collection documents.

MEDIATION: Should any claim or controversy arise between me and/or a legally authorized representative appointment by me, and the dentist, or Zimbi Dental, concerning the care and treatment rendered by the dentist to me, and effort shall be made by the parties involved to resolve the dispute through mediation appointed by Professional Insurance Exchange, should the dispute pertain to the quality of the dental services rendered. Costs for the mediation services shall be shared equally by the parties involved. The foregoing mediation agreement does not pertain to actions taken for the collection of debts owed as a result of dental services provided by Zimbi Dental.

I have read this Financial Policy, understand its contents, and agree by signing below to abide by the policy for all services provided by Zimbi Dental

Printed Name of Responsible Party | Signature of Responsible Party | Date

Election to Self-Pay for Services

At our dental practice, we educate our patients on, and give the options for, better/enhanced materials, technology, and medications that can enhance the comfort and longevity of treatment. It is well-known that INSURANCE WILL NOT PAY for these options. We feel the opportunity to have better/enhanced materials, technology, and medications should remain the patient's choice and should not be dictated by insurance companies.

Because there are no standardized dental codes (CDT Codes) for better/enhanced materials, technology and medications, they are automatically deemed "not covered" and "not payable' by insurance companies. We believe in being transparent. We document, with clear descriptions, these better/enhanced services using our own "C-Codes" which stay within the doctor/patient relationship and are NOT sent to insurance companies. Federal law requires patients to acknowledge and sign an agreement that "C-Codes" used by our office are not to be sent to their dental discount/insurance company.

DO NOT BILL TO INSURANCE
Patient HIPAA Restriction Request
Election to Self-Pay for Services [Section 13405 of Subtitle D of the HITECH Act 942USC 17935)]

I request that my dental healthcare provider(s) do not submit any/all "C Codes," performed by them on my behalf, to my health or dental discount/insurance company. By signing below, I acknowledge that I understand and agree that:

1. I am covered by a dental discount/insurance plan.
2. Despite the above coverage, I do not want my dental provider(s) to submit a claim to my medical or dental discount/insurance company for value-added/enhanced procedures identified as "C-Codes"
3. The dental service(s) provided, or that will be provided to me, have been verbally explained to me, and accompanied with a treatment plan, printed informational document(s), procedural consent forms, and/or informational consents for "C-Codes" with a refusal option on the same page.
4. I have freely chosen to self-pay for "C-Codes" knowing that they are not covered by my dental discount/insurance plan.

I have read this "Election to Self-Pay for Services" form and have had the opportunity to ask any questions I may have. Any questions I may have had about this form have been answered to my satisfaction.

Patient's Name	Signature of Patient, Legal Guardian, or Authorized Representative	Date

zimbi DENTAL

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