

Patient Information

Name _____ Birth Date _____
First MI Last

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ E-Mail _____

Social Security Number _____

Employer _____ Occupation _____ Work Phone _____

Business Address _____
Street City State Zip Code

Who may we thank for referring you to our office? _____

Emergency Contact (Closest Relative Not living with You)

Name Phone Number Relationship to you

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____
Street City State Zip Code

Social Security Number _____ Drivers License Number _____

Birth Date _____ Employer _____ Work Phone _____

Is this person currently a patient in our office? No Yes

Health History

Are you currently taking any medications? No Yes → _____

Are you currently taking any herbal supplements or vitamins? No Yes → _____

Are you allergic to or sensitive to any medications? No Yes → _____

Have you ever been diagnosed with any of the following? (Please check each box individually)

Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mitro Valve Prolapse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy/Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Joint Replacement	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Radiation Therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chemical Dependency	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have you been treated for any other serious illness? No Yes → _____

Have you ever been told to premedicate before dental appointments? No Yes

Do you smoke or use tobacco? No Yes

Women: Are you pregnant? No Yes

Dental History

Former Dentist's Name _____

Last Dental Visit _____

How often do you brush your teeth? _____

Do you feel nervous about having dental treatment? No Yes → _____

Have you ever had a bad experience at a dental office? No Yes → _____

Is there anything you dislike about your smile? _____

Patient/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Insurance Information

Do you have dental insurance? No Yes

Patient's Relationship to Subscriber Self Spouse Child Other

Subscriber information

Name _____

Date of Birth _____

Social Security Number _____

Employer _____ Work Phone Number _____

Work Address _____
Street City State Zip code

Policy Information

Insurance Company _____ Phone Number for Eligibility _____

Address _____
Street City State Zip code

Subscriber ID Number _____

Group Number _____

Are you covered under another insurance policy? No Yes

Patient's Relationship to Subscriber Self Spouse Child Other

Subscriber information

Name _____

Date of Birth _____

Social Security Number _____

Employer _____ Work Phone Number _____

Work Address _____
Street City State Zip code

Policy Information

Insurance Company _____ Phone Number for Eligibility _____

Address _____
Street City State Zip code

Subscriber ID Number _____

Group Number _____

Financial Policy

Payment is expected in full when services are rendered.

For your convenience we accept cash, check, money order, Visa, MasterCard, Discover, and American Express as payment for your dental services.

Extended term financing is available through CareCredit or the Dental Fee Plan (Ask front office for further details)

A courtesy discount of 5% is given for payment in full at the start of treatment to patients that do not have dental insurance.

Senior citizens (age 60 and over) are eligible for an additional 5% discount on their account if payment is received when services are initiated.

Minnesota Care Tax is added to all treatment per Minnesota State Law.

A 1.5% monthly finance charge (18% annually) will be applied to accounts beginning at 90 days.

Any unpaid accounts over **90 days** old will be turned over to a collection agency. ***You will be responsible for their fee.***

Missed or cancelled appointments

Missed (failed) or cancelled appointments without *at least 24 hours notice* will result in a charge.

Dental Insurance

We will assist you in every way to prepare all of your claims and help maximize your insurance benefit; however, *your estimated portion is due at the time of service*. Since *dental insurance is a contract between you and your insurance company*, we will request payment directly from you for any claims your insurance company has not paid within 60 days.

Please remember that dental insurance is not designed to be a pay-all, but merely an assistance.

We recommend the best treatment options for your dental health. Your insurance company may or may not benefit all procedures. Our recommendations are based on your dental needs and not your insurance coverage. We request that you understand your policy in advance so that together we can make the best treatment decisions.

Please feel free to present any concerns or questions to our office at 952-884-1308.

Signature

Date

Mitchell B. Olson, D.D.S., P.A.

Privacy Policy

This notice describes how health information about you may be used and disclosed and how you are able to get access to this information. Please review the information provided within this policy carefully. The privacy of your health information is important to our practice- thank you!

Our Legal Duty

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice describing 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 went into effect 1/1/2004 and will remain in effect until replaced.

We reserve the right to make changes to our privacy policy and terms at any time, provided such changes are permitted by applicable law. Any changes made to our privacy policy/terms will also include all prior health related information received prior to the change. In the circumstances that changes in the policy will go into effect, this notice will be replaced and the new notice will be available upon request.

You may request a copy of our office's privacy policy at any time.

Uses and disclosures of health information

We use and disclose health information about you for treatment, healthcare operations, and payment. 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 authorize 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, or by sending us a letter to the address at the end of this Notice. If you request copies, we will provide them to you free of charge. 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. 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: Sarah

Telephone: 952-884-1308 Fax: 952-884-3445 E-mail: mitchbolson@mn.rr.com

Address: 8400 Lyndale Avenue South Suite 8 Bloomington, MN 55420

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Mitchell B. Olson, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Signature

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)

