WELCOME

COLLEEN ISRAELSON, D.D.S.
7501 80TH ST. S.
COTTAGE GROVE, MN 55016

1 ABOUT YOU

Today's Date:____/____/____ Mr. ❑ Ms. ❑ Mrs. ❑

Patient Name:________________________________
LAST FIRST MI

What you prefer to be called:________________ Male ❑ Female ❑

Birthdate:____/____/____ Age:______ SS#:________

Mailing Address:________________________________

CITY STATE ZIP

Home Phone #: (______)________________

Work Phone #: (______)________________ Ext.______

Cell Phone #: (______)________________

E-mail Address:________________________________

Referred By:________________________________

Employer:________________________________

Employer's Address:________________________________

CITY STATE ZIP

Occupation:________________________________

If full time student – name of school________________

What time of day is best for your appointments? am / pm / either

2 INSURANCE INFO

Primary Dental Insurance

Co. Name:________________________________

Address:________________________________

CITY STATE ZIP

Phone #: (______)________________

Insured's ID#:________________________________

Group # (Plan, Local, or Policy #):________________

Insured's Name:________________________________

Relation:________________ Date of Birth:____/____/____

Insured's Employer:________________________________

Secondary Dental Insurance

Co. Name:________________________________

Address:________________________________

CITY STATE ZIP

Phone #: (______)________________

Insured's ID#:________________________________

Group # (Plan, Local, or Policy #):________________

Insured's Name________________________________

Relation:________________ Date of Birth:____/____/____

Insured's Employer:________________________________

3 ACCOUNT INFO

Person Responsible for Account **(Only custodial parent will be billed)**

Name:________________________________

Relation:________________________________

Billing Address:________________________________

CITY STATE ZIP

SS#:________________________________

Work Phone #: (______)________________

Payment method: ❑ Cash ❑ Check

________________________________ ____/____

❑ Credit Card – Enter card # above (if accepted)

______ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4 IN EVENT OF EMERGENCY

Whom should we contact?________________________________

Relation:________________________________

Home Phone #: (______)________________

Work Phone #: (______)________________ Ext.______

Cell Phone #: (______)________________

Who is your Medical Doctor?________________________________

Medical Doctor's Phone #: (______)________________

Medical Doctor's Address or Name of Clinic:________________

CITY STATE ZIP

5 NOTE

This office will help prepare any necessary reports and forms to assist in making collections from the insurance company to the patient. Any amount authorized to be paid directly to this office will be credited to the patient's account. It should be understood that all services furnished are charged directly to the patient, who is personally responsible for payment regardless of insurance status.

I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any account balance over 60 days. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency. Patients please review your benefit booklet or contract before having dental work started. The phone number for customer service is on your card for questions regarding benefits.

PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE PRIOR TO TREATMENT.

Signature:________________________ Date:________

PLEASE CONTINUE ON BACK

MEDICAL – DENTAL HISTORY

Patient Name: ______________________ Age: __________

Name of Last Dentist: ______________________ Phone #: __________

Their Address: ______________________ Date of last dental exam: __________

Are you under medical treatment now? Y/N If yes, please describe: ______________________

Have you had any major operations" Y/N Please Describe: ______________________

Have you ever had a serious accident involving head or jaw injuries? Y/N Please describe: ______________________

Have you had any adverse response to any drugs including penicillin, aspirin or local anesthetics (Novocain)? Y/N
Please describe drug and reaction: ______________________

Have you ever had any of the following? Please circle Y or N

Stroke....Y/N
Anemia....Y/N
Herpes....Y/N
Asthma....Y/N
Do you carry an inhaler....Y/N
Hay Fever....Y/N
Sinus Trouble....Y/N
Glaucoma....Y/N
Drug Abuse....Y/N
Alcohol Abuse....Y/N
Years of Sobriety__________

Nervous or Emotional Problems....Y/N
Heart Ailment....Y/N
High Blood Pressure....Y/N
Low Blood Pressure....Y/N
Respiratory Disease....Y/N
Diabetes....Y/N
Rheumatic Fever....Y/N
Heart or Valve Damage....Y/N
Need antibiotic coverage before dental work?....Y/N
Rheumatism or Arthritis....Y/N
Hearing Trouble....Y/N
Breast, Joint or any kind of Implant....Y/N

Blood Disease....Y/N
Liver Disease....Y/N
Kidney Disease....Y/N
Stomach Disease....Y/N
Intestinal Disease....Y/N
Venereal Disease....Y/N
AIDS or HIV....Y/N
Hepatitis A B C....Y/N
Yellow Jaundice....Y/N
Seizure Disease....Y/N
Limited Vision....Y/N

Are you allergic to any known materials resulting in hives, asthma, eczema, etc? If yes, please list: ______________________

____

Are you in general good health at this time? Y/N Special needs? I.e. wheelchair, can't lay back, etc: ______________________

______________________ Other problems? ______________________

Bleeding or healing problems? Y/N Do you have a history of fainting? Y/N Women: Are you pregnant: Y/N Due date:__________ Are you nursing? Y/N

Have you ever had any x-ray treatments (i.e. radiation therapy) Y/N Any loose or sensitive teeth Y/N How long have they been bothering you?________

Any growths or swellings in your mouth? Y/N Are you currently wearing a full or partial denture Y/N If yes, how old is it?________.

Do you use tobacco products? Y/N Have you had any serious trouble associated with previous dental work? Y/N

Please describe: ______________________

Do you routinely use local anesthetic (Novocain) for dental work? Y/N Nitrous oxide gas? Y/N

Please list all current medications and the reason you are taking them. Also include over-the-counter medications. Note: cocaine and other drugs can make dental treatment extremely dangerous!

List current medications and reason taken:

____
____
____
____
____
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____
____
____
____
____
____

UPDATE SECTION: (Note any changes from both sides of this form)

Today's Date:	Changes:	Initial:

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of ANY changes in the medical status of the patient.

Signature: ______________________ Date: __________

INFORMATION ABOUT OUR FINANCIAL AND PRIVACY POLICIES

Please read our Privacy Policy and sign where indicated.

We are required by applicable federal rules and state law to maintain the privacy of your health information. We are also required to provide you with a Notice of Privacy Practices about our privacy policy, our legal duties, and your rights concerning your health information. We provide this notice to each new patient, and any patient may request a copy of our notice at any time.

- I have been provided a copy of this office's Notice of Privacy Practices. I have had the opportunity to read this office's Notice of Privacy Practices and now give consent for this office's use and disclosure of my personal health information to carry out treatment, payment and health care operations as defined in the notice. Based on this, Colleen Israelson D.D.S. and her staff may request records pertinent to my case from all involved health care providers.
- You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or continue treating you if you revoke your consent. You would also be responsible for paying your balance in full on the date of service and submitting your own insurance claims etc.

I AGREE WITH THE ABOVE ITEMS * SIGN AND DATE____________________________________

OUR FINANCIAL POLICY

Please understand that your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. All patients must complete our information and medical form, insurance forms, HIPAA, and this form before receiving any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, Visa, Discover, and MasterCard. A 5% bookkeeping savings will be given to uninsured patients for paying in full with cash or a paper check on the date of service. A finance charge of 1.5% per statement period of 28 days will be charged at 60 days from the date of service. Please inform staff before treatment is started if payment cannot be made in full. *We charge a fee of $30.00 for returned checks.*

Regarding Insurance

We accept assignment of insurance benefits. However, you are responsible for using your benefits outlined in your contract correctly. We may not be a participating provider in your individual plan. You may be responsible for the difference between our charges and what your plan allows. We do require that you pay your estimated portion owed on the date of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with current insurance information. Your insurance policy is a contract between you and your insurance policy; we are not a party to that contract. If your insurance company has not paid your account in full within 90 days of being billed, the balance will be your responsibility. Our practice is committed to providing the best treatment for our patients. We do not base our care on what insurance plans allow, we treat your individual needs.

Minor patients

The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. We ask that a parent be present with the minor children. We have a form that can be filled out in advance if a parent will not be present at their child's visit. Unaccompanied minors', non-emergency treatment, will be denied unless the charges have been pre-authorized to an approved credit plan, credit card, or payment by cash at the time of service. Once a minor turns 18, they will be asked to complete and sign their own paperwork.

Missed Appointments

Our policy is to charge $50.00 for missed appointments, unless cancelled at least 24 hours in advance. We simply cannot afford to let time go to waste that could have been used by another patient. Please help us serve you better by keeping scheduled appointments. Please arrive 5 minutes early to update your information.

I have read and understand and agree to this financial policy. ***PLEASE SIGN & DATE BELOW:

____

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Protecting Your Confidential Health Information is Important to Us

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Patient Acknowledgment

Patient Name(s):____

____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

____

Patient Signature

Date ________ / ________ / ________

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

FM-0304 • © SmartPractice®

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY

(Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48.

COLLEEN ISRAELSON, D.D.S.
7501 80TH ST. S.
COTTAGE GROVE, MN 55016

49. NPI 1396813853

50. License Number D10501

51. SSN or TIN 61-1540974

52. Phone Number (651) 459-7888

52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56A. Provider Specialty Code

57. Phone Number

58. Additional Provider ID