BLENDE
DENTAL GROUP
HOME OF THE HOUSE CALL DENTISTS

390 Laurel Street, Suite # 310
(at Sacramento Street)
San Francisco, CA 94118
Tel: 415.563.4261
Fax: 415.563.1476
www.blendedentalgroup.com

150 East 58th Street
8th Floor Annex
New York, NY 10155
Tel: 646-461-1295
Fax: 646-652-7722
www.blendedentalgroup.com

Welcome to our practice.

The doctors and staff of The Blende Dental Group look forward to meeting you during your consultation with us. We would like to take a moment to thank you for giving us the opportunity to provide you with the highest quality dental care. With more than 40 years experience in dentistry, we are committed to patient comfort and safety.

During your first visit, we will perform a complete oral examination, take diagnostic photographs and review your dental x-rays so that we may provide you with a thorough assessment of your dental health. We will also strive to answer all of your questions and concerns as thoroughly as possible.

If you haven't already, please take a moment to learn more about our practice via our website: www.blendedentalgroup.com

In addition to the forms, attached, please have your dental benefits card available if you have dental insurance. We will gladly process your claim for you. However, as a reminder, you are responsible for your account and payment is due when services are rendered.

Please do not hesitate to contact us if you should have any questions or concerns.

Sincerely,

The Blende Dental Group Team

BLENDE
DENTAL GROUP
HOME OF THE HOUSE CALL DENTISTS

390 Laurel Street, Suite # 310
(at Sacramento Street)
San Francisco, CA 94118
Tel: 415.563.4261
Fax: 415.563.1476
www.blendedentalgroup.com

150 East 58th Street
8th Floor Annex
New York, NY 10155
Tel: 646-461-1295
Fax: 646-652-7722
www.blendedentalgroup.com

PATIENT CONTACT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ SSN: _____ Sex: M F

Home#: _____ Business#: _____ Cell#: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Height: _____ Weight: _____

Parent/Guardian Name: _____ Relation: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Business#: _____ Cell#: _____

Name of Primary Caretaker: _____ Phone#: _____

Emergency Contact (not living with you): _____ Relation: _____

Home#: _____ Business#: _____ Cell#: _____

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

PAYMENT INFORMATION

Name of Financial Guarantor: _____ Relation: _____

Home#: _____ Business#: _____ Cell#: _____

Address: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

PRIMARY:

Dental Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Ins #: _____ Group#: _____

Insured Name: _____

Relation: _____ Employer: _____

Date of Birth: _____ ID#: _____

SECONDARY:

Dental Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Ins #: _____ Group#: _____

Insured Name: _____

Relation: _____ Employer: _____

Date of Birth: _____ ID#: _____

MEDICAL INSURANCE

Carrier name: _____ Group#: _____ Phone#: _____

Insured Name: _____ ID#: _____ Date of Birth: _____

Pharmacy Name: _____ Phone # _____

Changing lives, one smile at a time: awake, asleep, or at home

PATIENT NAME _____

HEALTH HISTORY

1. Current primary care physician
   Physician name: _____ Phone#: _____
   Address: _____ City: _____ State: _____ Zip: _____

2. Other medical specialist seen within the last 2 years:
   Name: _____ Phone#: _____ Name: _____ Phone#: _____
   Name: _____ Phone#: _____ Name: _____ Phone#: _____

3. Are you currently taking any medications? ❑ Yes ❑ No
   If yes, please list name, dosage & medical condition (or attach list of medications): _____

4. Have you ever had an allergic reaction to any medications? ❑ Yes ❑ No
   If yes, please list medication & effects: _____

5. a. Have you ever taken Fenflouramine/Phentermine (FEN-PHEN) medication? ❑ Yes ❑ No
   If yes, have you had an echocardiogram? ❑ Yes ❑ No
   Date: _____ Results: _____
   b. Are you taking anticoagulant medications? (Coumadin, Warfarin, Plavix, Ticlid, Heparin) ❑ Yes ❑ No
   If yes, name of medication _____ how long taken? _____
   c. Are you taking or have you ever taken biphosphonate drugs? (Actonel, Aredia, Boniva, Didronel, Fosamax, Reclast, Skelid, Zometa) ❑ Yes ❑ No
   If yes, name of medication _____ how long taken? _____

6. Women, please answer the following additional questions:
   Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

7. Height: _____ Weight: _____

8. Do you smoke or use smokeless tobacco? ❑ Yes ❑ No

9. For our house call patients:
   a. Mobility: ❑ Ambulatory ❑ Walker ❑ Wheelchair ❑ Non-ambulatory
   b. Diet: ❑ No Restrictions ❑ Soft Mechanical ❑ Puree ❑ Feeding Tube
   c. Removable appliance(s) present? ❑ Yes ❑ No

10. Do you have a caregiver? ❑ Yes, they live with me ❑ Yes, part-time ❑ No

11. Do you have or have you ever had any of the following: (Please check all that apply)

	Yes	No		Yes	No		Yes	No		Yes	No
Alcohol Abuse:	❑	❑	Diabetes:	❑	❑	Hemophilia:	❑	❑	Rheumatic Fever:	❑	❑
Alzheimer's Disease:	❑	❑	Dementia:	❑	❑	Herpes:	❑	❑	Psychiatric Care:	❑	❑
Arthritis/Rheumatism:	❑	❑	Drug Abuse:	❑	❑	Hepatitis (A, B, C):	❑	❑	Stroke:	❑	❑
Anemia:	❑	❑	Dizziness/Fainting:	❑	❑	High Blood Pressure:	❑	❑	Thyroid (Hypo/Hyper):	❑	❑
Artificial (Joints, Limbs):	❑	❑	Emphysema:	❑	❑	HIV:	❑	❑	Ulcers:	❑	❑
Asthma:	❑	❑	Glaucoma:	❑	❑	Kidney disease:	❑	❑	Tuberculosis:	❑	❑
Cancer, Tumors:	❑	❑	Heart Attack:	❑	❑	Jaundice:	❑	❑	Venereal disease:	❑	❑
Blood transfusion:	❑	❑	Headaches, Migraines:	❑	❑	Liver disease:	❑	❑			
Chest Pain:	❑	❑	Heart Surgery:	❑	❑	Latex Sensitivity:	❑	❑			
Chemo/Radiation:	❑	❑	Heart Disease:	❑	❑	Mitral Valve Prolapse:	❑	❑			
Convulsions/Epilepsy:	❑	❑	Heart Murmur:	❑	❑	Pacemaker:	❑	❑			

12. Do you have or have you had any disease, condition or problem not on this list? _____

I understand that the information gathered on this medical history form is intended to help inform the Blende Dental Group staff of any pre-existing medical conditions so that the best course of treatment can be determined. I understand that failure to disclose this information could affect my own safety. I affirm that the medical information indicated here is accurate and complete.

Parent/Guardian Signature: _____ Date: _____
Patient Signature: _____ Date: _____

PATIENT NAME _____

BLENDE
DENTAL GROUP
HOME OF THE HOUSE CALL DENTISTS

DENTAL HISTORY

1. What is the reason for your visit today: _____

_____

2. On a scale from 1-10 (10 being satisfied):

	(dissatisfied) 1	2	3	4	5	6	7	8	9	10 (satisfied)
a. Where do you rate your dental health now?	○	○	○	○	○	○	○	○	○	○
b. Where would you like your dental health to be in 5 years?	○	○	○	○	○	○	○	○	○	○

3. Are you satisfied with your smile? ❑ Yes ❑ No

4. Are you inquiring about having all dental care done under General Anesthesia or IV Sedation? ❑ Yes ❑ No

5. What was the date of your last dental visit: _____ Dental Cleaning: _____ X-rays: _____

6. Have you ever had any unsatisfactory experiences with previous dental treatment or providers? ❑ Yes ❑ No

_____

_____

7. Have you ever been treated for periodontal (gum) disease? ❑ Yes ❑ No

8. Have you ever had orthodontic therapy or worn braces? ❑ Yes ❑ No

9. Do you clench or grind your teeth? ❑ Yes ❑ No

10. Do you have:

	Yes	No		Yes	No		Yes	No
Bleeding, sore gums:	❑	❑	Sensitivity to sweets:	❑	❑	Locking Jaw:	❑	❑
Loose teeth:	❑	❑	Sensitivity to biting:	❑	❑	Shifting of teeth:	❑	❑
Burning tongue/lips:	❑	❑	Unpleasant breath:	❑	❑	Change in bite:	❑	❑
Sensitivity to hot/cold:	❑	❑	Clicking Jaw:	❑	❑	Food impaction:	❑	❑

For patients with special needs:

11. How often do you: Brush _____ x's/day ❑ Assisted ❑ Unassisted

Floss _____ x's/day or week ❑ Assisted ❑ Unassisted

12. Do you use a standard or electric toothbrush? ❑ Standard ❑ Electric

13. Do you use a fluoride or plaque rinse? ❑ Yes ❑ No Type/Brand: _____

BLENDE
DENTAL GROUP
HOME OF THE HOUSE CALL DENTISTS

390 Laurel Street, Suite # 310
(at Sacramento Street)
San Francisco, CA 94118
Tel: 415.563.4261
Fax: 415.563.1476
www.blendedentalgroup.com

150 East 58th Street
8th Floor Annex
New York, NY 10155
Tel: 646-461-1295
Fax: 646-652-7722
www.blendedentalgroup.com

FINANCIAL/INSURANCE POLICY

Welcome to the The Blende Dental Group! It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations. The following is our office payment policy:

Payment for Services

Payment is due at the time services are rendered, as the The Blende Dental Group is a fee for service practice. For certain types of treatment, such as procedures involving sedation or anesthesia, payment will be required in advance of your scheduled surgery. We accept cash, debit cards, wire transfers, Visa, Master Card, American Express, money orders, and personal checks.

If you have Insurance

If you have dental insurance, we will be happy to help you receive reimbursement for your allowable benefits. While the filing of insurance claims is a courtesy that we extend to our patients, all charges and payments are your responsibility on the date that services are rendered. Please keep in mind that your insurance plan is a contract between you and the insurance company, and is in no way an obligation between that insurance company and The Blende Dental Group. After we file paperwork for you, it is your responsibility to follow-up with your insurer for reimbursement. We encourage you to read and understand your dental policy.

Procedures for payment/reimbursement:

- Payment is due in full at the time services are rendered.
- As a courtesy to you, our patient, we will submit a claim to your insurance carrier on your behalf for your reimbursement. Please present your valid insurance card at the front desk.
- Your insurance carrier will review your claim and make a determination of your payment. They may apply your fees to a deductible, require a co-pay, and/or deny coverage/payment. Some services may not be covered by your plan, or your insurance carrier may pay only a portion of the charges. We cannot know these amounts in advance; therefore, payment is your responsibility.
- Our office does not guarantee that you will receive reimbursement from your insurance company. Please contact your insurance company for answers to specific questions regarding your coverage, their payment policies and reimbursement procedures. Also, please call your insurance company to expedite claims if a claim has not been paid within 30 days.

Other Fees

Outstanding balances: Outstanding balances over 60 days are subject to collections fees and an interest rate charge of 18% Annual Percentage Rate.

We hope that by presenting our policies to you, we will avoid any misunderstandings, and therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information, please do not hesitate to ask - we are here to help.

I certify that I have read, understood, and received a copy of the above policy.
I understand my financial responsibility for dental treatment.

Name: _____ Date: _____

Patient/Guardian Signature: _____

BLENDE
DENTAL GROUP
HOME OF THE HOUSE CALL DENTISTS

390 Laurel Street, Suite # 310
(at Sacramento Street)
San Francisco, CA 94118
Tel: 415.563.4261
Fax: 415.563.1476
www.blendedentalgroup.com

150 East 58th Street
8th Floor Annex
New York, NY 10155
Tel: 646-461-1295
Fax: 646-652-7722
www.blendedentalgroup.com

CANCELLATION/MISSED APPOINTEMENT POLICY

Thank you for choosing The Blende Dental Group to treat your dental needs. It is our goal to provide you with the best care possible. When you become a patient of this practice, we commit to your treatment plan and deliver healthy and beautiful smiles in a medically safe and service-oriented setting. To that end, the dentists of The Blende Dental Group limit their selection of patients to those who are most motivated to begin a sequence of treatment appointments that will end up producing an elegant and predictable result. Because of the specialized nature of our practice and our commitment to excellence, we ask every patient to adhere to our cancellation policy.

We place a high value on our patients, and our front office staff will always try to accommodate your emergencies. However, failure to notify our office of a cancellation means that we cannot offer that time to other patients. For this reason, we enforce a fee for late cancellations and missed appointments. The number of days required for notice of cancellation and the late cancellation fee amount is dependant upon the type of appointment scheduled and the amount of time allotted for the appointment. Unforeseeable emergencies will be taken into consideration if a cancellation fee is assessed.

General and Hygiene Appointments require two business days (M-F) notice for cancellation/reschedule. A general appointment includes first examination, follow-up examinations, consultations, root planing, and prepping teeth for crowns, composites, or other restorations. The late cancellation fee for a general and hygiene appointments is $75.00 per hour for each hour allotted for the appointment.

If you are more than fifteen minutes late, we reserve the right to reschedule your appointment. Our time is as valuable as yours.

House Call Appointments require two business days (M-F) for cancellations/rescheduling.

Sedation Appointments require five business days (M-F) for cancellations/rescheduling.

When you originally committed to this appointment, we allotted a considerable amount of time for your case. Therefore, the appointment can only be cancelled in the event of a medical emergency by the patient's personal physician, speaking on the phone with Dr. Blende, or by the anesthesiologist. The late cancellation fees for these appointments will be assessed at one-third (33%) of the amount of the treatment plan estimate.

We acknowledge that we occasionally run behind schedule. We apologize, in advance, for these inconveniences, and ask for your understanding that dental emergencies occasionally create delays in our schedule. Please let us know if you have any questions about this policy. We appreciate your cooperation in this matter.

I certify that I have read, understood, and received a copy of the above policy.
I understand my financial responsibility for dental treatment.

Name: _____ Date: _____

Patient/Guardian Signature: _____

BLENDE
DENTAL GROUP
HOME OF THE HOUSE CALL DENTISTS

390 Laurel Street, Suite # 310
(at Sacramento Street)
San Francisco, CA 94118
Tel: 415.563.4261
Fax: 415.563.1476
www.blendedentalgroup.com

150 East 58th Street
8th Floor Annex
New York, NY 10155
Tel: 646-461-1295
Fax: 646-652-7722
www.blendedentalgroup.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

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

- ❑ Individual refused to sign
- ❑ Communications barrier prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify) _____

PATIENT NAME _____

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2015, 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 provide the new Notice at our practice location, and we will distribute it 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. Your Authorization: In addition to our use of your health information for the following purposes, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

PATIENT NAME _____

BLENDE
DENTAL GROUP
HOME OF THE HOUSE CALL DENTISTS

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 the protected health information of an 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0 for each page, $25 per hour for staff time to 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 January 1, 2015. 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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 Person: Carla Caramat, Practice Manager | Telephone: (800) 395-1152 | E-mail: carla@drblende.com