



270 Elmwood Road N Suite H-140, Marlton, NJ 08053
 Phone 856-291-6888, Fax 856-446-6662

Patient Information

Patient Name: _____ Today's Date: _____
Last, First MI (Preferred Name)

Gender: _____ Social Security #: _____ Birth Date: _____

Phone (Home): _____ Cell: _____

E-mail Address: _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Has the patient ever had any of the following? Please check those that apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | OTHER: |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures | |

Date of Last Dental Visit: _____ Reason for this visit: _____

• Has the patient ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Name of Primary Care Physician/Pediatrician: _____ Phone: _____

• Has the patient been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Is the patient now under the care of a physician? Yes No

If yes, please explain: _____

• Is the patient taking any medication? Yes No

If yes, please list: _____

How did you find out about our office? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any change in the above patient's health, I will inform this practice and doctors at the next appointment without fail.

 Signature of Patient/Parent/Legal Guardian/Personal Representative Date: _____

Patient's Name _____

Parent/Legal Guardian Information:

Name: _____ Male Female

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ (Cell): _____ (Work): _____

Address: _____

Street

Apartment #

City

State

Zip Code

Insurance Information

Primary

Insurance Holder's name: _____ **Date of Birth:** _____

Last

First

MI

Address: _____

Street

City

State

Zip Code

Insurance Company Name: _____

ID #: _____ **Group #:** _____

Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Child Other _____

Secondary

Insurance Holder's name: _____ **Date of Birth:** _____

Last

First

MI

Address: _____

Street

City

State

Zip Code

Insurance Company Name: _____

ID #: _____ **Group #:** _____

Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Child Other _____

Consent for Services

Patients with or without dental insurance understand that all dental services provided are charged directly to the patient/parent/legal guardian/guarantor and such person is personally and financially responsible for payment of all dental services provided. The undersigned hereby certifies that the above information I have given is correct to the best of my knowledge. I will not hold BMK Dental LLC/Gleam Dentistry (hereinafter Gleam Dentistry) or any member of the staff or employee thereof responsible for any errors or omissions that I may have made in the completion of these forms. As a condition of treatment by Gleam Dentistry, financial arrangements must be made in advance. All emergency dental services or any dental services performed without previous financial arrangements must be immediately paid for at the time services are rendered. The above named patient has insurance coverage with the dental insurance company's name as indicated above and assigns directly to Gleam Dentistry all insured benefits for services rendered. I hereby authorize Gleam Dentistry to release all information relating to the patient's dental care to secure the payments of benefits from the insurance company and authorize use of my signature below on all insurance submissions. I understand that Gleam Dentistry will assist in submitting the appropriate claim forms to the patient's insurance company and will credit any insurance payments to the patient's account. I understand that I am financially responsible for all charges whether or not said charges are paid in whole or in part by the insurance company. I authorize and assign payments of all dental benefits, otherwise payable to me, directly to Gleam Dentistry. A service charge of 1.33% per month (16% per annum) on the unpaid balance will be charged on all accounts not paid within 60 days, unless previously written financial arrangements have been made and satisfied. If the patient's account is more than 60 days overdue, the account may be sent to collections. I hereby authorize Gleam Dentistry to release all information relating to the patient's dental care to the collection agency in order to secure payments due. I further agree to reimburse Gleam Dentistry the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorney's fees, and legally permitted interest, that Gleam Dentistry incurs in such collection efforts. I grant permission to Gleam Dentistry to telephone me at home or at my work to discuss matters related to these forms. I authorize the Doctors and the Dental staff at Gleam Dentistry to perform the necessary dental services my child may need including, but not limited to, the use of nitrous oxide, x-rays, prophylaxis and fluoride treatment. **If it is necessary to cancel an appointment, it must be done 48 hours prior to the scheduled time of the appointment. I understand that there will be a charge of \$75 dollars for a missed appointment without said 48 hours notice. Failure to cancel appointment(s) without required notice/no show appointments 3 times or more will result in discharge of patient and family members from practice.** I certify that I have read and understand the above.

I, Parent/Legal Guardian of the above named patient give my permission for _____, relationship _____ to accompany the above named patient to his/her dental appointment and make any necessary medical and dental treatment decisions.

Signature: Patient/Parent/Legal Guardian/Personal Representative/Guarantor

Relationship to Patient

Date



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA)

<http://www.hhs.gov/ocr/hipaa/finalreg.html>

PATIENT/PARENT(S) / LEGAL GUARDIAN(S) / PERSONAL REPRESENTATIVE GIVING CONSENT

Patient's Name: _____
LAST, FIRST

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this consent form, you are consenting to BMK Dental LLC/Gleam Dentistry (hereinafter Gleam Dentistry) or any member of the staff or employee thereof, use and disclosure of the above named patient's protected health information to carry out treatment, payment activities and healthcare operations. This form is used to obtain acknowledgment that you have been notified that our Notice of Privacy Practices can be obtained from our office.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. This notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of the above named patient's protected health information, and of other important matters about the above named patient's protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Gleam Dentistry.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Gleam Dentistry. Please understand that revocation of this Consent 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 to continue treating you if you revoke this Consent.

SIGNATURE

I, the above named Patient / Parent(s) / Legal Guardian(s) / Personal Representative have had full opportunity to read and consider the contents of this Consent form and Gleam Dentistry Notice of Privacy Practices.

I understand that, by signing this Consent form, I am giving my consent to Gleam Dentistry to use and disclosure the above named patient's protected health information to carry out treatment, payment activities and health care operations. In addition I give permission to Gleam Dentistry to speak with either parent or either legal guardian concerning the above named patient's protected health information to carry out treatment, payment activities and health care operations. I acknowledge receipt of Gleam Dentistry Notice of Privacy Practices.

In addition to the above I also give permission to Gleam Dentistry to speak with the following person (s) concerning the above named patient:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____

If a Parent/Guardian/Personal Representative signs this consent on behalf of the Patient please complete the following:

Print Name of Parent/Legal Guardian/Personal Representative: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

For Office Use:

Office 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)



Dear Parent/Legal Guardian of: _____
 LAST, FIRST

We want to welcome you to our dental family. We pride ourselves in a family oriented environment. In order to provide your child with the highest quality of care please read the information below and ask any questions about anything you do not understand.

Anxiety Reducing Techniques

All effort will be made to obtain the cooperation of our dental patients by the use of Tell–Show-Do with friendliness, persuasion, humor, charm, gentleness, kindness and understanding. In some cases further techniques are needed when providing operative care such as fillings, etc. In order to gain cooperation, eliminate disruptive behavior or prevent a patient from causing injury to themselves, it may be necessary to use other anxiety reducing techniques.

Tell–Show-Do: The dentist or dental team explains to the child what is to be done using simple kid friendly terminology and repetition, then shows the child what is to be done by demonstrating with instruments on a model or the child’s or dentist's finger. The procedure is then preformed in the child’s mouth as described. Praise is used to reinforce cooperative behavior.

Positive Reinforcement: This technique rewards the child who displays behavior which is desirable with compliments, praise, pat on the back or a prize.

Mouth Props/Rubber Dams: A mouth prop or “tooth pillow” as we call it, is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc.) This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a “raincoat” placed on the area to be worked on to isolate the teeth and prevents any debris from being swallowed or going to the back of the throat.

Immobilization by the Dentist: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the dentist gently holds the child’s hands or upper body, stabilizing the child’s head between the dentist’s arm and body.

Immobilization by the Assistant: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the assistant gently holds the child’s hands, stabilizes the child’s head and or legs.

Relaxation Gas: Nitrous Oxide (laughing gas) and oxygen may be recommended to relax the child. This allows the child to sit in the chair longer, and allows the treatment to be completed in a comfortable manner for the child.

Insurance- Please understand that we accept insurance as a courtesy. We are happy to help with the process of submitting claims. However, understanding your insurance is ultimately your responsibility. The estimated out of pocket payment is due at the time of service.

Late and Missed Appointments- Please be aware that there is a charge of \$75 dollars for a missed appointment without 48 hours' notice. Three missed appointments will result in discharge from our practice. In order to provide an on time schedule of services, we ask you to be 10 minutes early to all appointments. If you are more than 10 minutes late, you may be asked to reschedule your appointment.

Copies of X Rays-We are always happy to provide you with copies of your child’s x-rays. There is a charge of \$25 dollars for all x-rays.

I authorize the Doctors and the Dental staff at Gleam Dentistry to perform the necessary dental services my child may need including, but not limited to, the use of nitrous oxide, x-rays, prophylaxis and fluoride treatment.

I _____ acknowledge that I have read the above and agree to the contents.

Printed Name of Parent/Legal Guardian/ Representative

Signature Parent/Legal Guardian/Representative

Date



Gleam Dentistry 856-291-6888

SUPPLEMENTAL INFORMED CONSENT DENTAL TREATMENT IN THE ERA OF COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as “Coronavirus,” at any time or any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at a grocery store, gym or restaurant. Nationwide social distancing has reduced the transmission of the Coronavirus. Although we have taken measures to enable social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental healthcare team members and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment? YES NO

PATIENT(S) NAME

PATIENT/PARENT’S SIGNATURE

DATE