O'KANE &
MONSSEN
FAMILY DENTISTRY

Welcome!

We appreciate your confidence and take great pride in providing high quality dental care for our patients. Enclosed you will find forms including a patient registration, health history, HIPAA policy, financial policy, as well as a records release form to send to your previous provider so we may obtain any prior imaging you had with them. **Please send this document to them as soon as possible.** The remainder of the forms should be completed prior to your appointment and furnished upon check-in along with your dental insurance card (if applicable). **If you require pre-medication prior to dental appointments, please be sure to take it as directed.**

Our office is located across from the old Ford Plant, one block west of Cretin Ave. We are in the Haskell's building on the second floor.

Our clinic hours are:
Monday – Wednesday 7 a.m. – 5 p.m
Thursday 7 a.m. – 4:30 p.m.
Friday 8 a.m. – 2 p.m.

We kindly ask that you arrive 10 minutes prior to your scheduled appointment time to complete the registration process.

Smile. Happy looks good on you.

Dr. Kristi Casey O'Kane
Dr. Brian Monssen
Dr. Sara Michel

2221 Ford Parkway
Suite 201
St. Paul, MN 55116

651-698-1242
smile@okanemonssen.com
okanemonssen.com

O'KANE & MONSSEN
FAMILY DENTISTRY

To help us meet your healthcare needs, please fill out this confidential form in its entirety. If you have any questions, or need assistance, please do not hesitate to ask us. Thank you.

Today's Date: _____ How did you hear about our office? _____

Patient Information

Last Name: _____ First Name: _____ MI: _____ Sex: M or F

DOB: _____ SSN: _____ Marital Status: S M D W

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

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

E-Mail Address: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Responsible Party Information (Only fill out this section if the information is different than above)

Last Name: _____ First Name: _____ MI: _____ Sex: M or F

DOB: _____ SSN: _____ Relation to Patient:_____

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

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

E-Mail Address: _____

Dental Insurance Information

Primary Insurance Carrier: _____ Employer Administering Policy: _____

Policy Holder Name: _____ DOB: _____ Relation to Patient: _____

Subscriber/Member ID#: _____ Group/Account #: _____

Secondary Insurance Carrier: _____ Employer Administering Policy: _____

Policy Holder Name: _____ DOB: _____ Relation to Patient: _____

Subscriber/Member ID#: _____ Group/Account #: _____

The above statements are true and I authorize the release of any medical/dental information asrequired by my insurance company. I also authorize payment of dental benefits to be made to O'Kane & Monssen Family Dentistry:

Signature: _____ Date: _____

Please submit dental insurance card(s) to front office personnel.

O`Kane _Monssen Family Dentistry

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	Yes No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

O'KANE & MONSSEN FAMILY DENTISTRY
ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____Patient DOB: _____

Address: _____ City: _____

Zip Code: _____ Home Phone: _____Cell Phone: _____

E-Mail: _____

SECTION B: To the patient/guardian, please read the following statements carefully.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice can accompany this consent upon request. We encourage you to read it carefully and completely before signing this consent.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Purpose of Acknowledgement: By signing this form, you acknowledge you had the opportunity to read our Notice of Privacy Act for O'Kane & Monssen Family Dentistry.

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 the Notice of Privacy Practices, including any revisions, of our notice at any time by contacting:

Marilee Maxwell
651-698-1242
2221 Ford Pkwy #201
St. Paul, MN 55116

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 the contact person listed above. 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.

Print Responsible Party Name:

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____**Date:** _____

If consent is signed by a personal representative on behalf of the patient, please complete the following:

Representative's Name: _____ Relationship to Patient: _____

If you are over 18 years of age, is O'Kane & Monssen Family Dentistry allowed to speak with anyone else, besides yourself, about your dental health? **Yes** or **No** If so, name/relationship:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

O'KANE & MONSSEN
FAMILY DENTISTRY

Financial Policy

Appointment Information:

Once an appointment is made, please remember that this time has been reserved for you. A minimum charge of $40.00 will be made for a missed or cancelled appointment without prior notification of at least 24 hours. If you are more than 15 minutes late for your appointment, you may be asked to reschedule.

Insurance Facts:

We accept many insurance plans and will help you maximize your yearly benefits. We will bill your insurance company as a courtesy to you. Your insurance company makes the final determination of your eligibility by the policy you or your employer has contracted with them. **We cannot guarantee any insurance payments**, even on given estimates. We require that your estimated patient portion be paid at the time services are rendered.

O'Kane and Monssen Family Dentistry's fees are based on the care, skill and judgement of the professionals delivering the services and by the cost of operating a dental office dedicated to excellence. Our office does not diagnose, render treatment, or establish fees according to any insurance tables or allowances.

Financial Options:

We accept Visa, MasterCard, Discover and American Express. We also have a partnership with CareCredit that offers extended payment options.

Charges to Account:

Payment is due at the time of service unless other payment arrangements have been made in advance. If your account becomes past due, we will take the steps necessary to collect this debt. There is a $30.00 fee for any returned checks by the bank.

Monthly Statements:

If you have a balance on your account, we will send you a statement. The balance on your statement is due and payable when the statement is issued. Your account is considered past due if it is not paid by the end of the month, unless other arrangements are approved in writing.

Any balances remaining over 60 days from the date of service will be subject to a $10.00 monthly late fee.

Print Patient Name Below:

I, _____, understand that I am ultimately responsible for all charges for dental services and materials regardless of my dental benefit plan. I also agree to pay any and all late fees and collection or legal costs incurred should this account be deemed uncollectable.

Signature of Patient/Guardian: _____ **Date:**_____

A copy of this agreement can be made available upon request.

O'KANE & MONSSEN
FAMILY DENTISTRY

AUTHORIZATION TO RELEASE RECORDS TO O'KANE & MONSSEN FROM A PREVIOUS OFFICE

Please complete and send to your previous dental provider prior to your appointment with us. Thank you.

Previous Dental Provider: _____

Address/Location:_____

Phone:_____ Fax: _____

E-Mail: _____

Please forward the dental records, including the most current Panoramic, FMX, and BWX, (no matter the date) for the following individuals:

Name:	**Date of Birth:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

To:

O'Kane & Monssen Family Dentistry
2221 Ford Parkway #201
St. Paul, Minnesota 55116

(P) 651-698-1242
(F) 651-696-1858
(E) smile@okanemonssen.com

Signature: _____ Date: _____

Dr. Kristi Casey O'Kane • Dr. Brian C. Monssen • Dr. Sara Michel

2221 Ford Parkway • Suite 201 • St. Paul, Minnesota 55116 • (651) 698-1242 • Fax (651) 696-1858
E-Mail: smile@okanemonssen.com • www.okanemonssen.com

O'KANE & MONSSEN
FAMILY DENTISTRY

AUTHORIZATION TO RELEASE RECORDS FROM O'KANE & MONSSEN TO ANOTHER OFFICE

I authorize records for the following patients:

_____ DOB:_____
_____ DOB:_____
_____ DOB:_____
_____ DOB:_____
_____ DOB:_____

To be released to:

Dr._____

Clinic Name:_____

Address:

_____

_____

_____

Clinic E-Mail:_____

_____ _____
Patient/Guardian Signature Date

Dr. Kristi Casey O'Kane • Dr. Brian C. Monssen • Dr. Sara Michel

2221 Ford Parkway • Suite 201 • St. Paul, Minnesota 55116 • (651) 698-1242 • Fax (651) 696-1858
E-Mail: smile@okanemonssen.com • www.okanemonssen.com