DENTAL PROFESSIONALS OF ALGONQUIN

All good things begin with a smile

Patient Information

Patient Name: _____ Date: _____
Last First M Preferred

Social Security #: _____ Birth Date: _____ Gender:

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

Which number to call first?: ☐ Home ☐ Work ☐ Cell Email: _____

Please check the appropriate box: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Address: _____
Street City State Zip Code

Preferred appointment times: Morning ☐ Afternoon ☐ Evening ☐ Any Time -- M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐

In case of emergency, who should we contact? _____ Phone#: _____

Emergency contacts relationship to you? _____

Party Responsible for Payment Information

The following information is for: ☐ Self; (info same as above) ☐ The patient's spouse ☐ The patient's guardian/parent ☐ Other _____

Name: _____ Relationship to patient: _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street City State Zip Code

Referral Information

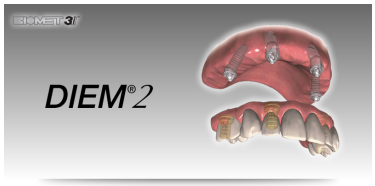
Whom may we thank for referring you to our practice? ☐ Another patient (friend) ☐ Another patient (relative)

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Community Magazine ☐ Other _____

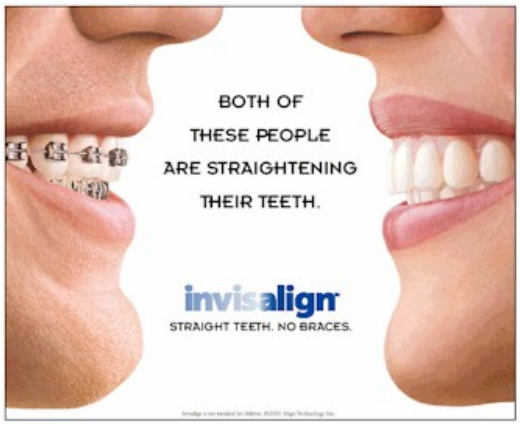
Name of person or office referring you to our practice: _____

Your teeth, like your fingerprints, are unique – no one else's are the same as yours. Many options exist to replace missing teeth but only one – **dental implants** – can provide the feel, function and appearance of natural teeth.

Dental Implants have changed the face of dentistry over the last 25 years. Dental implant surgery is a procedure that replaces damaged or missing teeth with artificial teeth that look and function much like real ones. Dental implant surgery can offer a welcome alternative to dentures or partials. Dental implants have the highest success rate of any implanted surgical device.



Click on image for more information



Click on image for more information

Insurance Form For New Patients

If you are an existing patient and have insurance changes (new employer or an employer has switched your insurance plan), please fill out the information below, then submit it electronically to our office. Thank you, we appreciate you sending your updated information for us to update it in a timely manner for your convenience.

Name of Insured: Last _____ First _____ MI _____

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address 1: _____

Insured's Address 2: _____

City: _____ State: _____ Zip Code: _____

Insured's Employee Name: _____

Employer Address 1: _____

Employer Address 2: _____

City: _____ State: _____ Zip Code: _____

Patients Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance Plan Name: _____

Insurance Address 1: _____

Insurance Address 2: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance Information (if applicable):

Name of Insured: Last _____ First _____ MI _____

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address 1: _____

Insured's Address 2: _____

City: _____ State: _____ Zip Code: _____

Insured's Employee Name: _____

Employer Address 1: _____

Employer Address 2: _____

City: _____ State: _____ Zip Code: _____

Patients Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance Plan Name: _____

Insurance Address 1: _____

Insurance Address 2: _____

City: _____ State: _____ Zip Code: _____

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Patient Name: _____

Patient Medical History

Physician: _____ Office Phone#: _____ Last Exam Date: _____

	YES	NO
1. Are you under medical treatment?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you allergic to or have you had any reactions to the following: -Local Anesthetics (e.g. Novocain)	☐	☐
-Penicillin	☐	☐
-Sulfa Drugs	☐	☐
-Barbiturates/other medicines	☐	☐
-Iodine	☐	☐
-Aspirin	☐	☐
-Any Metals (e.g. nickel, etc)	☐	☐
-Latex Rubber	☐	☐
-Other:		

8. Do you require antibiotics/pre-med prior to dental work?
9. Have you ever taken Bisphosphonates?

9. Have you ever had any of the following? **Please check those that apply:**

☐ High Blood Pressure	☐ Heart Disease	☐ Chest Pains	☐ Persistent Cough
☐ Low Blood Pressure	☐ Cardiac Pacemaker	☐ Stroke	☐ Other:_____
☐ Rheumatic Fever	☐ Heart Murmur	☐ Hay Fever/Allergies	**WOMEN ONLY:**
☐ Swollen Ankles	☐ Angina	☐ Tuberculosis	☐ Pregnancy
☐ Fainting/ Seizures	☐ Frequently Tired	☐ Radiation Therapy	Due Date: _____
☐ Asthma	☐ Anemia	☐ Glaucoma	☐ Nursing
☐ Heart Attack	☐ Emphysema	☐ Recent Weight Loss	☐ Oral Contraceptives
☐ Epilepsy/Convulsions	☐ Cancer	☐ Liver Disease	
☐ Leukemia	☐ Arthritis	☐ Sinus Problems	
☐ Diabetes	☐ Joint Replacement	☐ Stomach Problems/Ulcer	
☐ Kidney Disease	☐ Hepatitis/Jaundice	☐ Respiratory Problems	
☐ AIDS or HIV Infection	☐ Thyroid Problem	☐ Mitral Valve Prolapse	
☐ Sexually Trans. Disease	☐ Heart Trouble	☐ FamilyHistory ofDiabetes	

Patient Dental History

Name of previous Dentist & Location: _____ Date of last exam: _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Are you experiencing any of the following problems in you jaw:		
-Clicking	☐	☐
-Pain (joint, ear, side of face)	☐	☐
-Difficulty in opening or closing	☐	☐
-Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐

	YES	NO
11. Have you ever had any difficult extractions?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials? If yes, date of placement	☐	☐
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
15. Do you like your smile?	☐	☐
16. How many times a day do you brush?		
17. How many times a day do you floss?		
18. How much coffee/soda do you drink a day?		
19. Do you have any dental problems you would like to discuss with the dentist or hygienest?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis & the records of any treatment or examination rendered to me or child during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient/Guardian:_____

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FINANCIAL POLICY

We will assist you in every way possible to maximize your dental insurance benefits, including retrieving estimated benefits, filling out and filing the claim forms at no charge. **Nevertheless, your policy is an agreement between you and your insurance company, not between your insurance company and our office. We can make no guarantee of any coverage, but we'll do our best to see that you receive your maximum benefits.**

PLEASE INITIAL BELOW, ACKNOWLEDGING THAT YOU HAVE READ & AGREE TO COMPLY:

_____ **I understand that I am responsible for my total obligation, should my dental benefits result in less coverage than anticipated, regardless of the reason of nonpayment.** *Not all of the services we provide are covered benefits. Benefits differ from one company's benefits to another. Fees for non-covered services, along with deductibles & co-payments are due at the time of treatment.*

_____ **I understand that Dental Professionals will only file my primary dental insurance claims.** *You may file the secondary insurance claim. (We are more than happy to provide you with any additional information you may need to process these claims)*

_____ **I am responsible for keeping track of and being familiar with my dental insurance benefits (including procedure frequencies, waiting periods and yearly maximums/deductibles).** *We try our best to keep track of and monitor your benefits, but it is essentially the policyholder's responsibility. Please ask the front desk at any time for any type of procedure codes/information on upcoming appointments, so that you may call your insurance to find out limitation and frequency details.*

_____ **I authorize payment for services rendered to be paid directly to Dental Professionals. If information is supplied at the time of visit, then insurance claims will be filed with the contracted carriers.**

_____ **I understand that payment is due AT THE TIME THE SERVICE ARE RENDERED. In the case of dental insurance, my *estimated* patient portion would be due at the time of service. Once my dental insurance has issued payment for their portion, any remaining balance would become my full responsibility.** *Please note there will be a finance charge of 2% per month (of the full balance) applied on any remaining balance after 60 days.*

_____ **Upon the circumstance that my account is sent to a collection agency,** *(this action would incur after 90 days of billing statements and a final notice)* **my total account balance would be increased by 30% for collection costs. This 30% increase would include attorney fees, court costs and all other related costs.**

_____ **I am aware that when I make a payment, Dental Professionals accepts cash, personal checks, VISA, MasterCard, American Express, Citi Health, and Care Credit.**

_____ **I understand that extended payment plans (i.e. Citi Health Card & Care Credit) are available upon credit approval. Otherwise, my payment is expected at the time my services are performed.** *When extensive dental care is necessary, arrangements may be made with the financial coordinator. Please have these options reviewed prior to beginning treatment.*

_____ **I understand that any checks returned to our office due to insufficient funds will be charged a $40.00 reprocessing fee.** *Once a check is returned, Dental Professionals will no longer be able to accept a payment by check from you or a family member.*

_____ **In the case of minors: the parent or guardian accompanying the minor to the appointment is responsible for full payment. In the case of divorce/seperation, the parent/guardian that brought the minor to the appointment is resposible for payment, no exceptions**

_____ **Our dental office will charge a $50.00 fee for calcellations and appointment failures without a 24 hour notice.**

Responsible Party Signature _____ **Date** _____

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Patient Name: _____

OSHA / HIPAA

To ensure the safety of our staff and provide privacy to all of our patients (in compliance with OSHA Standards, and the Federal Governments HIPAA Privacy Policy Act), **we request that ONLY patients receiving treatment enter the patient operatories and surrounding areas.**

In the instance of small children, parents may accompany their child to the treatment area to see that they are settled before returning to the waiting room.

We thank you for your cooperation.

I have read the above office policy, and agree to abide by the set HIPAA Privacy/OSHA standards for my personal privacy, and the privacy of others.

Signature _____ Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been given the opportunity to review/receive a copy of this office's Notice of Privacy Practices.

You may refuse to sign this Acknowledgement

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

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 accompanies 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Dental Professionals of Algonquin.

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 Dental Professionals of Algonquin. 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.

I have had full opportunity to read 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 health care operations.

Please print name _____ Date _____

Signature _____

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DENTAL RECORDS / INFORMATION RELEASE FORM

OPTIONAL FORM THAT MAY BE COMPLETED BY THE PATIENT IF HE/SHE IS OVER 18 YEARS OLD.

Please note, if this form is not completed, our office is prohibited from releasing any information regarding the patient (over 18 years old) to **any** individual, other than the patient.

I, _____ give Dental Professionals of Algonquin permission to discuss and release any dental records and/or information regarding treatment, payment, and health operations to the following individuals:

- _____ (Name) _____ (Individual's relationship to patient)
- _____ (Name) _____ (Individual's relationship to patient)
- _____ (Name) _____ (Individual's relationship to patient)
- _____ (Name) _____ (Individual's relationship to patient)
- _____ (Name) _____ (Individual's relationship to patient)

Parent Signature _____ Date_____

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Patient Authorization to Release Confidential Information

Patient Name: _____
(Please Print Name)

Patient Address: _____

_____

Date of Birth: _____

I, _____hereby request and authorize _____to forward copies of any and all clinical treatment records and information concerning my care to:

Dental Professionals of Algonquin, P.C.
1485 Merchant Drive
Algonquin, IL 60102
Phone: 847-45-TOOTH
Email: dental@45tooth.com

The records include, but not limited to: personal patient information, medical and dental histories, and radiographs.

I expressly release from liability the above-named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

*Patient E-Signature:*_____ *Date Requested:* _____

Electronic signatures are legally binding as covered by the ESIGN act of 2000 and Uniform Electronic Transactions Act (UETA) in the USA

Emailed/Faxed Request To: _____

By: _____