Welcome to..

Park Family Dental!

PATIENT REGISTRATION

First Name: _____ Middle Initial: ____ Last Name: _____ Nickname: _____

How did you find us? ❍Friend/Family ❍Web Search ❍Insurance Company ❍Other: _____

Patient Information

Address: _____
City: _____ State_____ Zip_____
Home Phone: (____) _____Work :(____) _____Ext: _____ Cellular (____) _____
Legal Sex: ❍Male ❍Female Birth Date: ____/____/_____ Drivers Lic: _____
Social Security #:_____/____/_____ (**REQUIRED IF OVER 18)** E-Mail:_____@_____.com

Responsible Party **(Person responsible for patient and for paying for services):**

❍**Self** (stop here) ❍**Someone Else** (Complete following information)
Relationship to Patient: ❍Spouse ❍Parent/Guardian ❍Child ❍Other_____
First Name_____ Middle Initial: _____Last Name: _____
Address: _____
City: _____ State_____ Zip_____
Home Phone: (____) _____Work :(____) _____Ext: _____ Cellular (____) _____
Legal Sex: ❍Male ❍Female Birth Date: ____/____/_____ Drivers Lic: _____
Social Security #:_____/____/_____ (**REQUIRED IF OVER 18)** E-Mail:_____@_____.com

Primary Insurance:

❍**Check if none** (You may stop here)
❍**Check if same as responsible party** (move on to **B**)
❍**Check if same as patient** (move on to **B**)
❍**Check if other** (please fill out **A** & **B**)

A. Name of Policy Holder: _____Birth Date: ____/____/_____ Legal Sex: ❍Male ❍Female
Soc Sec: _____/___/_____**(REQUIRED).** Relationship to Patient: ❍Spouse ❍Parent/Guardian ❍Child ❍Other _____

B. Insurance Company: _____ Phone (____) _____
Do you get this insurance through an employer? ❍Yes ❍No Employer Name or Other Source:_____

Secondary Insurance:

❍**Check if none** (You may stop here)
❍**Check if same as responsible party** (move on to **B**)
❍**Check if same as patient** (move on to **B**)
❍**Check if other** (please fill out **A** & **B**)

A. Name of Policy Holder: _____Birth Date: ____/____/_____ Legal Sex: ❍Male ❍Female
Soc Sec: _____/___/_____**(REQUIRED).** Relationship to Patient: ❍Spouse ❍Parent/Guardian ❍Child ❍Other _____

B. Insurance Company: _____ Phone (____) _____
Do you get this insurance through an employer? ❍Yes ❍No Employer Name or Other Source: _____

Medical History

Your mouth is the portal to the rest of your body. Most health issues are co-related to your dental status. Certain health conditions and medications can interfere with the dental work you will have done. Choosing not to provide your health information will not only put you at risk but may also alter the success of your dental treatment. It is important that this be filled out thoroughly and honestly. Thank you for your cooperation!

Are you under a physician's care now? ❍Yes ❍No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❍Yes ❍No If yes, please explain what and when: _____

_____

Have you ever had a serious head or neck injury? ❍Yes ❍No If yes, please explain what and when: _____

_____

Are you taking any medications, pills, or drugs? ❍Yes ❍No If yes, please LIST: _____

_____

_____

***Do you take, or have you taken, Phen-Fen or Redux?** ❍Yes ❍No

***Have you Ever Taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?** ❍Yes ❍No

***Are you on a special diet?** ❍Yes ❍No

***Do you use tobacco?** ❍Yes ❍No

***Do you use controlled substances?** ❍Yes ❍No

WOMEN ONLY: Are you…**Pregnant/Trying?** ❍Yes **(circle)** ❍No **Nursing?** ❍Yes ❍No **Taking Contraceptives?** ❍Yes ❍No

ALLERGIES: Are you allergic to any of the following?

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

❍Other please explain: _____

Please mark if you have, or have had, any of the following…

❍AIDS/HIV Positive	❍Cortisone Medicine	❍Hemophilia	❍Recent Weight Loss
❍Alzheimer's disease	❍Depression	❍Hepatitis A	❍Renal Dialysis
❍Anaphylaxis	❍Diabetes	❍Hepatitis B or C	❍Rheumatic Fever
❍Anemia	❍Drug Addiction	❍Herpes	❍Rheumatism
❍Angina	❍Easily Winded	❍High Blood Pressure	❍Scarlet Fever
❍Anxiety Disorder	❍Emphysema	❍High Cholesterol	❍Shingles
❍Arthritis/ Gout	❍Epilepsy or Seizures	❍Hives or Rash	❍Sickle Cell Disease
❍Artificial Heart Valve	❍Excessive Bleeding	❍Hypoglycemia	❍Sinus Trouble
❍Artificial Joint	❍Excessive Thirst	❍Irregular Heartbeat	❍Spina Bifida
❍Asthma	❍Fainting Spells/Dizziness	❍Kidney Problems	❍Stomach/Intestinal Disease
❍Blood Disease	❍Frequent Cough	❍Leukemia	❍Stroke
❍Blood Transfusion	❍Frequent Diarrhea	❍Liver Disease	❍Swelling of Limbs
❍Breathing Problem	❍Frequent Headaches	❍Low Blood Pressure	❍Thyroid Disease
❍Bruise Easily	❍Genital Herpes	❍Lung Disease	❍Tonsillitis
❍Cancer	❍Glaucoma	❍Mitral Valve Prolapse	❍Tuberculosis
❍Chemotherapy	❍Hay Fever	❍Osteoporosis	❍Tumors/Growths
❍Chest Pains	❍Heart Attack/Failure	❍Pain in Jaw Joints	❍Ulcers
❍Cold Sores/Fever Blisters	❍Heart Murmur	❍Parathyroid Disease	❍Venereal Disease
❍Congenital Heart Disorder	❍Heart Pacemaker	❍Psychiatric Care	❍Yellow Jaundice
❍Convulsions	❍Heart Trouble/Disease	❍Radiation Treatments	

Have you ever had any serious illness not listed above? ❍Yes ❍No If yes, please explain: _____

_____

Do you have any comments or special needs? _____

_____

_____

EMERGENCY CONTACTS: NAME: _____ PHONE NUMBER:_____

NAME: _____ PHONE NUMBER:_____

To the best of my knowledge, the questions on this form have been accurately and honestly answered. I understand that providing incorrect information and/or withholding 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 _____ **Date** _____

PARK FAMILY DENTAL - Financial Policy & Consent to Treatment

Financial policy

We ask for all patients to pay for their treatment **in full** on the date of each visit to our office unless prior arrangements have been made. Our office staff is always willing and available to discuss any billing matters or questions should they arise. The following is our financial policy.

Dental Insurance: If you have dental insurance, the office will work with you to maximize your insurance benefits. As a courtesy, we will also assist you in filing claims with your insurance company. It is understood that the practice will diagnose treatment based on your dental health and **not** your insurance coverage (If your insurance company won't pay for it, it does not mean that you don't need it). It is further understood that your insurance is a **third party** hired by **you**; therefore, **you are fully responsible** for all fees charged by this office regardless of your insurance coverage. Most insurance companies respond to claims within 3-4 weeks. We will send you a monthly statement. Please call your insurance company if your statement does not reflect payment within this time frame. Any remaining balance after your insurance company has responded is **your responsibility**. If payment is not received from your insurance company within **60 days**, the balance becomes **your responsibility. You**, the patient, will have to contact your insurance company to determine why payment has not been made. Your complete dental insurance information must be presented at the time services are provided and it is your responsibility to make sure we have accurate insurance carrier and billing information at every appointment**. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered, or falsified to obtain coverage by insurance.**

Medical Insurance & 3rd Party Insurances: Medical/ Auto insurance will be billed as a courtesy to you. However, they typically do not tend to respond well to dental claims. It is your responsibility to follow up with them on payment. If no payment is received within **60 days,** the balance becomes your responsibility and is due immediately. Should this happen, you can try to file your own claim for reimbursement.

Dental Care Financing: We have arranged special financing with certain outside financing companies to reduce the financial barriers for our patients in receiving optimal care. Please inquire with us if you are interested. We do not carry account balances in our office.

Past Due Balances: Account balances over **60 days** will be subject to a charged interest rate of 1.5% per month or 18% annually.

Estimates: Any fees quoted by our office are strictly an estimate and not a guarantee of coverage or payment. In the event clinical conditions warrant a modification in treatment and fees it is your responsibility to let us know if you would like to be notified of the associated fees prior to proceeding. All estimates quoted for treatment will remain in effect for **90 days**, and treatment thereafter is subject to change without notice. Any patient that requires multiple visits to finish treatment (root canals, crowns, dentures etc.), will be billed for the entire treatment on the first visit. This balance will remain in effect, even if they do not show up to finish the treatment.

Returned Checks: A fee of **$35.00** will be charged for returned checks, chargebacks, or NSF. Payment in full must be paid with **cash** within 10 days.

Collections: In the event of default, you agree to pay legal interest on the debt, collection costs, and attorney fees required for collection of this note.

Assignment of Benefits (For Insurance Companies): I hereby guarantee all charges incurred by this office. I hereby assign and direct my insurance company to pay any and all benefits for dental services under this claim directly to the provider. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

Consent to Treatment

I, _____ consent to be a patient at Park Family Dental. I agree to receiving a radiographic and clinical examination. **I also understand and consent to the following:**

1. I understand that I may undergo procedures in all phases of dentistry including preventative dentistry, periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and **complete medical history**, supply a **full list** of my medications with dosages. I consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. I understand that **no guarantees** can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. My treatment plan may change at any time, and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental staff.
4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy (outlined above). I understand that even if an insurance pre-estimate is given by an insurance company, I am responsible for ***any*** costs that my insurance does not cover.
5. I have read and understood the financial policy, assignment of benefits, and consent to treatment. I understand that I am welcome to ask questions about any aspects of my dental care and will request information if I am confused. I am responsible for clarifying any aspects of my treatment I am unsure about.

_____ _____

Patient Name Date

_____ _____

Patient's signature (or parent/guardian if minor) Witness

Park Family Dental

Appointment Late Arrival, Cancellation, & No-Show Policy

It is our goal to accommodate our patient's need for office visits in a timely manner while providing quality personalized dental care. This requires careful planning and coordination on our end. We understand that emergencies arise from time to time, just as they do for us; however, when a patient fails an appointment or cancels without adequate notice, we cannot use that time to meet the needs of other patients. We respectfully request your understanding and agreement to our policy as it is stated below.

Late Arrival

Patients are asked to arrive 5 minutes **before** their scheduled appointment time. This allows adequate time for check-in and allows us to start your visit/treatment at your scheduled time.

*A grace period of **10 minutes** will be permitted for unforeseen delays a patient may encounter while traveling to the office for their scheduled appointment. If a patient arrives 11 minutes or more late for their appointment, we will need to reschedule for another day. We appreciate phone calls ahead to let us know you are running behind. However, the 10-minute grace period still applies whether you call or not.

Cancellation/Rescheduling Policy

We kindly ask that you provide us with at least a 48-hour notice to cancel or reschedule your appointment. This allows us adequate time to fill your appointment spot with another patient in need. To cancel or reschedule an appointment, you may call our office at 815-267-7878. If we do not answer, you may leave a voicemail. Alternatively, you may send text us at 888-625-1228 or email us at plainfield@theparkfamilydental.com. We will use the timestamp on the voicemail/email/message as the time you cancelled.

*No action will be taken if an appointment is cancelled or rescheduled with **more than 48 hours'** notice.

Late Cancellation/Rescheduling

If an appointment is cancelled or rescheduled with a **24-to-48-hour notice** it will be considered a late cancellation. Frequent late cancellations may result in the same consequences as a broken appointment. This is reserved to be decided at our discretion.

No Show/Broken Appointments

If an appointment is cancelled or rescheduled with **less than 24 hours'** notice it will be considered a No Show/Broken appointment.

***As a courtesy, we will allow **one** broken appointment per patient after receipt of this notice. This will not count against you.

***If you have **3 or more** broken appointments, your account will be **permanently** marked with habitual noncompliance. At this point we will send you a letter informing you that your account has entered this stage and it will reiterate the terms below.

***3 or more** broken appointments will result in a 4-6 week waiting period to reschedule and schedule **ALL** future appointments.

***Also, if **3 or more** appointments are broken during our prime hours (9-10am, 3-7pm, and Saturdays), those hours will no longer be available to you for scheduling for ANY future appointments.

***4 broken appointments** will result in a non-refundable deposit to schedule **ALL** future appointments. All prior listed terms will also apply. See chart below for the fee schedule.

If you schedule a…. **30-minute to 1-hour** appointment …….. **$75.00** deposit

1.5-hour appointment…….. **$150.00** deposit **2-hour** appointment …….. **$200.00** deposit

2.5-hour appointment …….. **$250.00** deposit **3-hour and up** appointment …….. **$300.00** deposit

*The duration of the appointments is based on the time needed to adequately complete the procedure being scheduled. There will be no exceptions. This deposit will need to be paid at the time of scheduling. These fees are not covered by your insurance company.

If you do not show up to a deposited appointment, your deposit will be used as a broken appointment fee to reimburse us for our lost time. If you do come to your appointment, this balance will be applied towards your treatment primarily and anything leftover can be saved on your account for future treatment or refunded to you.

WE RESERVE THE RIGHT TO **DISMISS** YOU FROM OUR PRACTICE AT **ANY TIME** IF 3 OR MORE APPOINTMENTS ARE BROKEN. THIS WILL BE DECIDED AT OUR DISCRETION.

We may excuse a broken appointment if there is good cause. If you have a valid reason and do not want your broken appointment to be held against you, you may email us a written explanation at plainfield@theparkfamilydental.com. Please include your name and date of birth. If you do not have email access, you may send a letter to our office.

I have received, understand, and agree to the Appointment Late Arrival, Cancellation, & No-Show Policy as listed above.

Printed Name of patient: _____ Relationship to Patient: _____

Signature of patient (guardian if minor): _____ Date: _____

Notice of Privacy Policy

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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must provide patients with a written Notice of Privacy Policy. The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be provided to patients. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, collection agencies etc. When these services are contacted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it 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.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

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.
  We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
- **Accounting of Disclosures:** 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. 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. We will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation 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 must explain the reason for the amendment.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, access to your health information, amending or restricting the use or disclosure of your health information, or requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.

Park Family Dental
24047 W Lockport St. Ste 207
Plainfield, IL 60544
815-267-7878

Park Family Dental
2303 W Roscoe St.
Chicago, IL 60618
773-883-9199

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY
***YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

By signing below, I acknowledge that I have received a copy of this Notice of Privacy Policy. (A COPY IS AVAILABLE UPON YOUR REQUEST)

PRINTED NAME: _____ DATE: _____

SIGNATURE:_____ RELATIONSHIP TO PATIENT: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of privacy policy but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communication Barrier prohibited the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (please specify) _____