DUPAGE FAMILY DENTAL NEW PATIENT REGISTRATION

GENERAL INFORMATION

-

Name:_____ **Date:** _____

Home Address: _____ **City/Sate/Zip:** _____

Telephone: Home _____ **Work** _____ **Cell** _____

Email: _____

Birthdate: _____ **SS#** _____ **Gender:** ___ **Male** ___ **Female**

Marital Status: ___ **Single** ___ **Married** ___ **Widowed** ___ **Separated** ___ **Divorced**

Employer: _____ **Occupation:** _____

Work Address: _____ **City/Sate/Zip:** _____

Spouse or Parent Name: _____ **Relationship:** _____

Telephone: Home _____ **Work** _____ **Cell**_____

Birthdate: _____ **SS#** _____

Employer: _____ **Occupation:** _____

DENTAL INSURANCE

Primary Insurance **Secondary Insurance**

Name of Policy Holder: _____ **Name of Policy Holder:**_____

SS# _____ **ID#** _____ **SS#** _____ **ID#** _____

Insurance Company: _____ **Insurance Company:**_____

Address: _____ **Address:** _____

Phone: _____ **Phone:** _____

EMERGENCY CONTACT

Name:_____ **Date:** _____

Home Address: _____ **City/Sate/Zip:** _____

Telephone: Home _____ **Work** _____ **Cell** _____

CONTACT PREFERENCES

Preferred Contact Method: ____ **Home Phone** ____ **Work Phone** ____ **Cell Phone** ____ **Email**

May we use your email address to send important news? ____ **Yes** ____ **NO**

DuPage Family Dental
630-588-1700

Patient: _____

Employer: _____

Claim/Group: _____

SS#/ ID#: _____

I hereby instruct and direct that _____ Insurance Company to pay by check made out and mailed to:

DuPpage Family Dental
1N141 County Farm Rd Ste 150
Winfield, IL 60190

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o DuPage Family Dental
1N141 County Farm Rd Ste 150
Winfield, IL 60190

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to that above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____
Signature of Policyholder Date

_____ _____
Signature of Claimant, if other than Policyholder Date

HIPAA Notice of Privacy Practices

DuPage Family Dental, P.C.
1N141 County Farm Rd Suite 150
Winfield. IL 60190

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health or condition and related dental or health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your dental/health care with a third party. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your dental care services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If your dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Dental Care Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

MEDICAL and DENTAL HISTORY

Please write in ink. The questions below are important in delivering safe dental treatment. There may be additional questions asked regarding this questionnaire. Your responses to this questionnaire and subsequent interview with the dentist will be considered confidential. It may be necessary to contact your physician or other health care provider to fully evaluate your health status, therefore we ask that you sign the permission to release information for when this need arises.

Name, address and phone # of my physician: _____

_____

Date of last doctor visit: _____ Reason for visit: _____

List any prescription or over the counter medications you currently take:

_____

_____

List any allergies you have: _____

Have you had any serious illness, operations or hospitalizations? If yes, what was done and when?

_____

_____

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

Please write in YES, NO or N/A (not applicable). For any that are YES, please describe.

1 - Artificial or damaged heart valve? . . . . . _____

2 - Rhuematic fever, heart murmur or congenital heart disease? . . . . . _____

3 - Heart trouble, heart attack, angina, high blood pressure, heart surgery, pacemaker, stroke or irregular heart beats? . . . . . _____

4 - Diabetes? . . . . . _____

5 - Hepatitis, jaundice or liver disease? . . . . . _____

6 - Respiratory problems, emphysema, asthma, hayfever or tuberculosis? . . . . . _____

7 - Venereal or sexually transmitted disease? . . . . . _____

8 - Cancer, chemotherapy, radiotherapy? . . . . . _____

9 - Kidney problems or renal dialysis? . . . . . _____

10 - Epilepsy or other neurological disease? . . . . . _____

11 - HIV+, ARC or AIDS? . . . . . _____

12 - Blood transfusion, abnormal bleeding, anemia? . . . . _____

13 - Serious injury to head or neck? . . . . . _____

14 - Tumors or growths? . . . . . _____

15 - Implants, organ or joint replacements? . . . . . _____

For women only:

1 - Are you pregnant? . . . . . _____

2 - Are you taking birth control pills? . . . . . _____

3 - Are you currently nursing an infant? . . . . . _____

Do you smoke? If YES, describe what type and quantity: _____

Date of last dental visit: _____ Reason for visit: _____

With regard to past dental treatment, have you ever had any of the following?

Please write in YES, NO or N/A (not applicable). For any that are YES, please describe.

1 - Had an allergic reaction to any medications or materials used? . . . . _____

2 - Felt faint or lightheaded? . . . . . _____

3 - Experienced prolonged or abnormal bleeding? . . . . . _____

4 - Had complications during or following a dental procedure? . . . . . _____

How often do you brush? _____ Floss? _____

Do you have or have had any of the following:

1 - Bleeding gums when brushing? . . . . _____

2 - Food packing between teeth? . . . . . _____

3 - Teeth sensitivity to hot, cold or biting? . . _____

4 - Sore jaw muscles? . . . . . _____

5 - Clicking or pain in the jaw joint? . . . . . _____

6 - Grinding or clenching teeth? _____

7 - Orthodontics (braces)? . . . _____

8 - Cold sores, canker sores? . _____

9 - Teeth shifting or loosening? . _____

10 - Partials or dentures? . . . _____

Reason for today's dental visit: _____

Please list other information or conditions regarding your medical or dental health that you feel may be important or otherwise not covered in the above questions:

_____

_____

Note: Please let the office know of any changes in your health status as soon as possible.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries above, have been answered to my satisfaction. I will not hold the dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I also grant permission to Sandpiper Dental and its agents to release health information I have provided as well as information regarding my dental treatment to third party payors involved and /or other health care providers.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **Relationship to patient:** _____

Do not write below this line FOR OFFICE USE ONLY

DENTIST'S HX REVIEW and ADDITIONAL NOTES:

_____

_____

_____

Medical History Updates:

Date:	Notes/Findings:	Initials:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. WE HONOR ALL PPO DENTAL INSURANCES. Payments may be made using cash, check, credit, or debit cards. Flex spending can also be used for dental treatment. We also offer CARECREDIT, which is a financing option available only for healthcare expenses.

Optional payment terms:

1. Financial agreements are made with the doctor prior to any procedures being completed.
2. **For major work half of the payment is needed at the beginning of treatment, and the other half when the work is completed.**
3. Any treatment under $300 must be paid in full the date of service.
4. Term Loan: By arrangements with CARECREDIT we can offer patients upon approval, a flexible low to no interest payment plan, no down payment, no annual fee and no prepayment penalty. Ask for an application.

KEEPING APPOINTMENTS:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hour notice for any cancelled appointment. **Same day cancellations will be charged a fee of $35. The $35 needs to be paid in full prior to scheduling the next appointment.** If you fail to come to your appointment on more than 3 occassions, we have the right to dismiss you from the office.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient's name (please print) _____

Patient's signature and date _____