Teutopolis Family Dental

206 N. Pearl St. – Teutopolis, IL 62467

PATIENT REGISTRATION

PATIENT INFORMATION: (Confidential)

Name (First/Last/MI):_____ Preferred/Nickname: _____

Birthdate: _____/_____/_____ Social Security #: _____ Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

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

Home Phone: _____ Cell Phone: _____

Person to contact in case of an Emergency: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY: (For Minors Only)

Name (First/Last/MI):_____Birthdate: _____/_____/_____ Social Security #: _____

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

Email: _____ Home Phone: _____ Cell Phone: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

INSURANCE:

Dental Insurance Information: (Primary Carrier)	Dental Insurance Information: (Secondary Carrier)
Insured's Name:	**Insured's Name:**
Insured's SS#: **Insured's DOB:**	**Insured's SS#:** **Insured's DOB:**
Insured's Employer:	**Insured's Employer:**
Insurance Company Name:	**Insurance Company Name:**
Insurance Company Address:	**Insurance Company Address:**
Insurance Company Phone# :	**Insurance Company Phone#:**
Member/Policy/ID #:	**Member/Policy/ID #:**
Group #: **Local:**	**Group #:** **Local:**

FINANCIAL POLICY:

WE RESERVE THE RIGHT TO BILL $50.00 PER HOUR SCHEDULED FOR NO SHOW APPOINTMENTS

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care; so you may attain optimum oral health. It is required that you understand, agree and sign this financial policy prior to treatment. Please note payment of your bill is considered part of your treatment. Payment is due at the time services are provided. Our office accepts cash, personal check, MasterCard, Visa, Discover and CareCredit. Outside financing is available upon request and approval.
Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; the patient will be responsible for all collection and /or legal fees up to 40%.
Insurance covered patients:

- As a courtesy, we will help process all insurance claims. A treatment estimate will be provided to you for services. This estimate is not a guarantee of coverage or payment from your insurance. Your insurance company and your plan benefit will ultimately determine the amount paid. We will do all we can to provide you with an accurate estimate as possible.
- All charges incurred are the patient/guardian's responsibility regardless of insurance coverage. We must emphasize as your dental care provider; our relationship is with you and not your insurance company. Your insurance coverage is a contract between you, your employer and your insurance company. Our office is not a party to that contract. It is your responsibility to be aware if we are in or out of network with your plan.
- You are responsible for your deductible & co-payment at the time the services are rendered. If payment cannot be made services may be rescheduled.
- Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our service area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.
- We will bill your insurance for you. Signing this form instructs and authorizes your insurance company to pay our office directly.

CONSENT:

I consent to the exam and treatment offered to me by this office. I understand my information may be used to further my dental care. I consent to the release of protected information to my medical physician and/or specialty dental professionals, such as but not limited to orthodontist, endodontics and oral surgeons. Furthermore, I understand and agree to all the terms and conditions of my financial obligations as listed above. I authorize my insurance company to pay this office directly for services performed. I understand and agree all fees are my responsibility regardless of insurance status. I will be responsible for finance, collection and /or attorneys fees on all overdue balances.

_____ Date: _____

Patient or Parent/Guardian Signature

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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 take, 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	If yes:
Do you use tobacco? (What and How Much)	○ Yes ○ No	If yes:
Do you use controlled substances?	○ 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 Allergy?

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
Anemia ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Angina ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
		High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/ Gout ○ Yes ○ No	Emphysema ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Join ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Fainting Spells/ Dizziness ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressures ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsilitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Hay Fever ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Attack/Failure ○ 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 ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

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.

CONSENT: the undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate and verbally consent by patient or legal guardian to be used by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated pending I give verbal consent and/or sign the appropriate consent forms for the procedures. I also understand the use of anesthetic agents embody a certain risk and are associated with any dental procedure requiring anesthetic. Though the risks are very low, I , the patient agree to ask questions of the doctor before administration of any drug or anesthetic should I have additional concerns or require further clarity. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Patient/Guardian Signature Date Dentist Signature

Patient Name: _____

PRIVACY CONSENT

You have the right to review our office's full privacy notice prior to signing this consent.

Your protected health information: such as names, dates, phone numbers, home addresses, social security numbers, and insurance information may be used in connection with your treatment and payment of your account. You may revoke this consent at any time in writing. However, such revocation will not be effective until written notice is received by this office.

At times, we may update our privacy notice. If we do, we will post a copy of the changes in the office. Changes to this notice will not take effect prior to the revised notice date. Copies of the revised notice will be made available upon request.

Thank you for your cooperation.

Insured patients: by signing below you are authorizing Teutopolis Family Dental to release protected health information regarding your treatment. This information includes dates, treatment, names, demographic information, social security and insurance numbers.

_____ _____

Print Patient Name Patient or Parent/Guardian Signature

_____

Date

AUTHORIZATION TO RELEASE INFORMATION

All patients: authorization is needed to release protected health information, such as appointment times, to anyone other than the patient. **Without this authorization we will not release any information about this patient.** Please list below the names and relationship to the person(s), organizations and/or physicians you, the patient, authorize access to your dental information:

_____ _____

Name & Relationship to Patient Name & Relationship to Patient

_____ _____

Name & Relationship to Patient Name & Relationship to Patient

I hereby give my authorization to release information to the above-listed names. Please release the following information:
(Check all that apply):

❑ All Records ❑ Appointment times/dates ❑ Dental/Hygiene Notes
❑ Billing Records ❑ X-rays ❑ Treatment Plans

_____ _____

Patient or Parent/Guardian Signature Date

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

❑Individual refused to sign ❑Communication barriers prohibited obtaining the acknowledgement ❑An emergency situation prohibited obtaining the acknowledgment

❑Other: _____.