

**WELCOME TO
WEBSTER DENTAL CARE OF HOFFMAN ESTATES**

Patient Information

Date _____

Name _____ **Nickname** _____
Last First Initial

Birthdate _____ **Male** ___ **Female** ___

Social Security # _____ **Drivers License#** _____

Address _____
Street Apt# City State Zip

Phone# _____
Home Cell Work Email

Dental Insurance Information

Primary Insurance:

Name of Insured _____ **DOB** _____ **SS#** _____

Name of Employer _____ **Insurance Co** _____

Group # _____ **ID#** _____ **Ins Phone#** _____

Claims Address _____

Secondary Insurance:

Name of Insured _____ **DOB** _____ **SS#** _____

Name of Employer _____ **Insurance Co** _____

Group # _____ **ID#** _____ **Ins Phone#** _____

Claims Address _____

Emergency Contact Name and Phone # _____

Has any member of your family been treated in our office? _____

Who may we thank for referring you to our office? _____

Authorization:

I hereby authorize payment directly to Webster Dental Care of Hoffman Estates of the group insurance benefits otherwise payable to me. I hereby authorize Webster Dental Care to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about by dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party Signature

Patient's Name _____

Birthdate _____

Date of last dental visit _____ For What Service? _____

Any unusual dental problems? ___Yes ___No Explain: _____

Any injuries to mouth or teeth? ___Yes ___No Explain: _____

Is fluoride taken in any form? ___Yes ___No Any unhappy dental experience? ___Yes ___No

Please circle any oral habits that apply: Thumb-sucking, Mouth breathing, Biting Objects, Tongue thrust, Clenching/grinding teeth

Medical History

1. Physician's Name & Phone Number _____

2. Are you under physician's care?..... YES NO

3. Are you taking any medications or substances?..... YES NO

(If yes, please list on form) -----> _____

4. Do you routinely take health related substances?(vitamins) YES NO _____

5. Do you have any other allergies?..... YES NO _____

6. Do you have any problems with penicillin,antibiotics, _____

anesthetics or other medications?..... YES NO _____

7. Are you sensitive to any metals or latex?..... YES NO _____

8. Are you pregnant or suspect you may be?..... YES NO _____

9. Do you use any birth control medications?..... YES NO _____

10. Have you been told you have heart disease?..... YES NO _____

11. Do you have a pacemaker or an artificial heart valve?..... YES NO _____

12. Have you ever had rheumatic fever?..... YES NO _____

13. Are you aware of any heart murmurs?..... YES NO _____

14. Do you have high or low blood pressure?..... YES NO _____

15. Have you had a serious illness or major surgery?..... YES NO

If so, explain _____

16. Have you had radiation treatment, chemo treatment?..... YES NO

17. Do you have inflammatory diseases such as arthritis or _____

rheumatism?..... YES NO

18. Do you have any artificial joints/prosthesis?..... YES NO

19. Do you have any blood disorders, anemia, leukemia?..... YES NO

20. Have you ever experienced excessive bleeding?..... YES NO

21. Do you have any stomach, kidney, liver problems?..... YES NO

22. Are you diabetic?..... YES NO

23. Do you have asthma?..... YES NO

24. Do you have epilepsy or seizure disorder?..... YES NO

25. Do you or have you had venereal disease?..... YES NO

26. Have you tested positive for HIV or AIDS?..... YES NO

27. Have you had or do you test positive for hepatitis?..... YES NO

28. Do you or have you had T.B.?..... YES NO

29. Do you smoke, chew, use snuff or other tobacco?..... YES NO

30. Do you consume alcoholic beverages?..... YES NO

31. Do you use controlled substances(illegal drugs)?..... YES NO

32. Have you had psychiatric treatment?..... YES NO

33. Do you have any disease, condition or problem not listed? YES NO

Explain _____

34. Is there anything we should know about you health not _____

covered on this form? YES NO

I certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

SIGNATURE OF PATIENT OR GUARDIAN _____

DATE _____

CONSENT FOR TREATMENT

1. I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed necessary to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize the Doctor and/or hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance may not cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.
3. I agree to the use of anesthetics sedatives and other medications as necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs that I may be taking in order to minimize these risks.
4. A fee of \$50 will be charged for appointments cancelled without a 24 hour cancellation notice.

Patient or Guardian Name (Printed)

Patient or Guardian Signature

Date

Webster Dental Care Payment Policy

Thank you for choosing our practice. This agreement is provided to you to clarify our payment policies. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you.

Insurance. We participate in all indemnity insurance plans. Knowledge of your insurance benefits is **your** responsibility. We do not take any HMO or DMO insurance plans. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and deductibles. All co-payments, co-insurance and/or deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and/or deductibles from patients may be considered insurance fraud. Our office accepts Visa, Mastercard, American Express and Discover Cards as well as cash, checks and money orders.

Non-covered services. Please be aware that certain procedures may not be covered by your insurance. **If services are not covered by your insurance or if you do not have insurance, payment is expected at the time of service unless payment arrangements were made in advance.** Please be advised that we have several methods of payment plans.

Proof of insurance. We will ask to make a copy of your insurance card and ask that you complete our patient information forms before being seen by a doctor or hygienist. We may ask for a photo identification to verify who you are.

Claim of submission. We will submit your claims for you to your insurance company and we will, within reason, attempt to help you get your insurance claims paid. Your insurance company may need you to supply certain information directly. **It is your responsibility to comply with their request.**

Coverage changes. Insurance companies have very strict requirements with regard to filing deadlines for reimbursement of claims. **Please notify us immediately of any insurance changes.** If your insurance company does not pay your claim in 45 days, the balance will be automatically billed to you and payment will be expected within 10 days of billing.

Late payments. An interest charge of 1.5% per month is assessed to all accounts that are past due. Failure to pay your bill within 90 days will result in your account being turned over to a collection agency and reporting to the credit bureau. There will be a \$45.00 fee for any NSF check.

I have read and understand the payment policy and agree to abide by its guidelines. I understand that, if head of household, it covers entire household. You give us permission to check your credit and employment history and to answer questions about your credit history with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Patient or Guardian Name (Printed)

Patient or Guardian Signature

Date

DENTAL NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL 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 & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a copy of this notice form us upon receipt.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may require a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free: (877) 696-6775

WEBSTER DENTAL CARE OF HOFFMAN ESTATES, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the **Notice of Privacy Practices** of this office.

Name (Please Print)

Signature

Date

Please Note: It is your right to refuse to sign this acknowledgement.

Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Other:

