ADULT REGISTRATION FORM

Welcome! *Please complete the following confidential information*

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ E-MAIL ADDRESS _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF SUBSCRIBER _____ ID OR SS # _____
(First) (Middle) (Last)

NAME OF EMPLOYER _____ NAME OF INSURANCE COMPANY: _____

GROUP/POLICY # _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

SECONDARY DENTAL INSURANCE INFORMATION:

NAME OF SUBSCRIBER _____ ID OR SS # _____
(First) (Middle) (Last)

NAME OF EMPLOYER _____ NAME OF INSURANCE COMPANY: _____

GROUP/POLICY # _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

CONSENT:

I hereby authorize payment of the dental benefits directly to Sommers Family Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, if applicable.

I ACKNOWLEDGE THAT I AM THE PERSON RESPONSIBLE FOR THIS BILL.

Patient/Guardian's Signature _____ **Date** _____

CHILD REGISTRATION FORM
(ANYONE UNDER AGE 18)

Welcome! *Please complete the following confidential information*

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)
DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

FATHER'S INFORMATION

NAME _____
(First) (Middle) (Last)
ADDRESS _____SOCIAL SECURITY # _____ BIRTHDATE _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ E-MAIL ADDRESS _____

EMPLOYER INFORMATION: _____

MOTHER'S INFORMATION

NAME _____
(First) (Middle) (Last)
ADDRESS _____ SOCIAL SECURITY # _____ BIRTHDATE _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ E-MAIL ADDRESS _____

EMPLOYER INFORMATION: _____

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ ID # _____
(First) (Middle) (Last)

DATE OF BIRTH _____ EMPLOYER _____

SECONDARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ ID # _____
(First) (Middle) (Last)

DATE OF BIRTH _____ EMPLOYER _____

CONSENT:

I hereby authorize payment of the dental benefits directly to Sommers Family Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, if applicable.

I ACKNOWLEDGE THAT I AM THE PERSON RESPONSIBLE FOR THIS BILL.

Parent/Guardian's Signature _____ **Date** _____

Medical History

Patient Name:_____ **Birth Date:**_____

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

If you need additional space, please use the comments section below

Are you under a physician's care now?	O Yes	O No	If yes, please explain_____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes, please explain_____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, please explain_____
Are you taking medications, pills or drugs?	O Yes	O No	If yes, please explain_____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	
Are you on a special diet?	O Yes	O No	
Do you use tobacco?	O Yes	O No	
Do you use controlled substances?	O Yes	O No	

Women: Are you pregnant, trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following? O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa Drugs O Other If yes, please explain_____

Do you have, or have you had, any of the following, please circle Yes or No

Aids/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Therapy	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stroke	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Tonsilitis	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Lyme Disease	Yes No	Tuberculosis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Mitral Valve Prolapse	Yes No	Tumors or Groths	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Osteoporosis	Yes No	Ulcers	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Pain In Jaw Joints	Yes No	Venereal Disease	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Parathyroid Disease	Yes No	Yellow Juandice	Yes No
				Psychiatric Care	Yes No	Stomach/Intestinal Disease	Yes No

Have you ever had any serious illness not listed above? Yes or 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.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ **DATE** _____

Financial Policy

Patients without insurance are responsible for their balance in full on the day services are rendered unless other payment arrangements have been made.

For those patients who are covered by insurance, we will accept assignments of benefits. Most insurance plans do not cover all of the cost of treatment. You are expected to pay your deductible and your portion of the estimated charges the day services are rendered. We will estimate as closely as possible your coverage, but until we actually receive payment from the insurance company, it is just an estimate. We will help you as much as we can with your insurance company, but the ultimate responsibility lies with you.

All patients are expected to pay by cash, check, or credit card the day the service is rendered unless care credit free financing arrangements have been made.

Any balance that is 30 days old will be assessed a $50 late fee and for each additional month that the balance is past due.

All accounts with a balance over 90 days old can be assessed a monthly service charge of 1.5% of the balance, unless other written arrangements have been made. In addition, any accounts sent to the collection agency or attorney will have an “administration/collection fee” of 50% of the outstanding balance plus all court costs and attorney fees if applicable.

I understand and agree to the above financial policy.

_____

Responsible Party Signature Date

Sommers Family Dental
1940 W. Galena Blvd. Suite 3
Aurora, IL 60506
(630) 892-7041

Keeping Appointments

Please understand that your dental health is very important to us as it is to you. Your appointments are reserved especially for you so that we can provide the best care possible.

We understand that emergencies are unpredictable, however if you miss an appointment or fail to give a 24 - 48 hour notice, not due to an emergency, your account will be charged $50.00.

If you need to change your appointment, have any questions or require additional information regarding your appointment(s), please contact our office at (630) 892-7041.

_____

Responsible Party Signature Date

Sommers Family Dental
1940 W. Galena Blvd. Suite 3
Aurora, IL 60506
(630) 892-7041

Acknowledgement of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

Sommers Family Dental
1940 W. Galena Blvd. Suite 3
Aurora, IL 60506
(630) 892-7041

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) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **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 include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/@Notice of Privacy Practices.doc officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to

you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

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 certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- 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 request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA 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
877-696-6775 (toll-free)