Patient Information

1 Patient Information

First Name _____

Last Name _____

M.I. _____ Preferred Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Who/what referred you to our office? _____

Sex: ❑ Male ❑ Female

Marital Status: ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed

Birthdate (MM/DD/YYYY) _____

Social Sec.: _____

Email: _____

Would you like to receive a text message from us to remind you of your appointment? ❑ Yes ❑ No

Check all that apply. This person is the:
❑ Patient ❑ Policy Holder ❑ Responsible Party

2 Insurance Information

Name of Policy Holder _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Work Home _____

Cell Phone _____

Sex: ❑ Male ❑ Female

Marital Status: ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed

Birthdate (MM/DD/YYYY) _____

Social Sec.: _____

Relationship to Patient _____

Name of Employer _____

Primary Insurance

Insurance Co. Name _____

Group Number _____

Secondary Insurance

Insurance Co. Name _____

Group Number _____

3 Responsible Party

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Home _____

Cell Phone _____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed

Birthdate (MM/DD/YYYY) _____

Social Sec.: _____

4 Authorization for Release of Identifying Health Information and Acknowledgement of Reciept of Privacy Practices

I authorize the professional office of my dentist, **(Dr. Saqib H. Mohajir - Pinewood Dental, PC)** to release all necessary health information identifying me to the following recipients only:

1.) My primary care physician, and/or medical/dental specialists, to aid in the diagnosis or treatment of my medical or dental health.

2.) My insurance company, to allow for payment of any claims made by this office toward my dental care. I assign all insurance benefits, otherwise payable to me, to the treating doctor for services rendered. I authorize the use of the signature below on all insurance submissions.

I HAVE READ AND UNDERSTAND THE ABOVE FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Dated _____ **Patient signature** _____

If you are signing as a representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Patient Medical History

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: _____

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

Are you on special diet? ❍ Yes ❍ No If yes, please explain: _____

Have you had any metal rods, pins or implants placed? ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco? ❍ Yes ❍ No If yes, how much? (pack/day) _____

Do you use controlled substances? ❍ Yes ❍ No _____

MEDICATIONS List any medications, pills or drugs you are currently taking:

_____

_____

Women: Are you? ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

ALLERGIES Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine
☐ Acrylic ☐ Metal ☐ Local Anesthetics
☐ Latex ☐ Other If yes, please explain:

_____

_____

HEALTH HISTORY Do you currently have, or have you ever had, any of the following conditions?

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

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

_____

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.

NAME OF PATIENT _____ DOB _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Financial Policy

At Pinewood Dental, our ultimate goal is your dental health and wellness. That's why we always present you with the best dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental insurance benefits but some do not. If you have dental benefits, congratulations! You are extremely fortunate. Here are some important points you should know:

Initial

_____ • Your dental benefits are based upon a contract made between you and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans **will never pay for completion of your dental care.** They are meant only to assist you.

_____ • We currently accept a large number of PPO insurance plans. This means we work with literally hundreds of companies. Although we can maintain computerized histories of payments by a given company, they do change; therefore it is **impossible to give you a guaranteed quote** at the time of service. We estimate your portion based on the most up-to-date information we have but it is **ONLY AN ESTIMATE.** If you would like exact out of pocket figures, we can submit a "pre-treatment authorization" with your insurance company. Keep in mind this is not a guarantee of coverage and it may delay treatment.

_____ • We will bill your insurance company as a courtesy. If insurance does not pay within 90 days, Pinewood Dental reserves the right to request payment in full for services from you and let you collect the insurance funds due to you. **This is rare**, but it is important that you recognize that the insurance you have is a legal contract between **YOU** and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, **you are responsible for all charges incurred in our office**.

_____ • Pinewood Dental does require payment in full for your portion **at the time of service**. We accept MasterCard, Visa, American Express, Discover, cash and checks. If you are in need of payment plans, we also work with CareCredit which offers 6 or 12 month "same as cash" no interest financing. Our staff can assist you in the application process.

_____ • A specific amount of time is **reserved especially for you** and we strongly encourage all patients to keep their appointments. If you must change your appointment, **we require at least 24 hours notice to avoid a $20 cancellation fee.**

I have read and agree with the above conditions.

Print Name_____ Date_____

Patient/Parent signature_____

1150 State Street
Lemont, IL 60439
(708) 364-0641

PRIVACY POLICY

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.

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care. We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment: We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations: We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed. We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law. We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights: In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed above. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.