We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you! We look forward to working with you in maintaining your dental health!

Patient Information

Date_____ Home Phone (___)_____Cell Phone (___)_____

Name _____Soc. Sec. #:_____
Last Name First Name Initial

Address_____

City_____ State_____ Zip Code_____ E-Mail_____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐Widowed ☐Separated ☐ Divorced

Patient Employed By: _____ Occupation: _____

How did you hear about us? _____

In Case of An Emergency who should be notified? _____

Telephone Number (____)_____

Primary Insurance:

Person Responsible for Account_____
Last Name First Name Initial

Relationship to Patient _____ Birth date: _____ Soc. Sec.# _____

Address _____ Phone (___)_____

City _____ State_____ Zip _____

Employed By _____ Occupation _____

Business Address _____ Business Phone (___)_____

Insurance Company _____

Contact #_____ Group #_____ Subscriber#_____

Name of other dependents covered under this plan _____

Additional Insurance:

Is patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber Name _____
Last Name First Name Initial

Relationship to Patient _____ Birth date: _____ Soc. Sec.# _____

Address _____ Phone ( ) _____

City _____ State_____ Zip _____

Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Insurance Company _____

Contact #_____ Group #_____ Subscriber#_____

Name of other dependents covered under this plan_____

Dental History

Reason for today's visit_____ Date of last dental care _____

Former Dentist _____ _____ Date of last dental X-rays _____

Address _____

Preferred Pharmacy: _____

Check if you a have problem with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping of jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐Sensitivity to cold	☐Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

Medical History

Physicians Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastic (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dezfenfluramine). ☐ Yes ☐ No

Are you a smoker? If yes, please describe amount per day _____

Have you had any serious illness or operations? If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, please give appropriate dates_____

(Woman)Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐ Yes ☐ No

Check if you have had problems with the following:

☐ Anemia	☐Cortisone Treatments	☐Hepatitis	☐Scarlet fever
☐ Arthritis, Rheumatism	☐Cough, Persistent	☐High Blood Pressure	☐Shortness of breath
☐Artificial Heart Valves	☐Cough up blood	☐HIV/AIDS	☐Skin Rash
☐Artificial Joints	☐Diabetes	☐ Jaw Pain	☐Stroke
☐Asthma	☐ Epilepsy	☐ Kidney Disease	☐Swelling of feet or ankles
☐Back Problems	☐Fainting	☐Liver Disease	☐ thyroid problems
☐Blood disease	☐Glaucoma	☐Mitral Valve Problems	☐ Tobacco Habit
☐Cancer	☐Headaches	☐Pacemaker	☐Tonsillitis
☐Chemical Dependency	☐Heart Murmur	☐Radiation Treatment	☐ Tuberculosis
☐Chemotherapy	☐Heart Problems	☐Respiratory Disease	☐Ulcer
☐Circulatory Problems	☐Hemophilia	☐Rheumatic Fever	☐Venereal Disease

Medications

_____

_____

Allergies

_____

_____

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY AGREEMENT

I hereby assign to Dental Designers all of my claims and rights to payment under any insurance policy for which I am a beneficiary. By the assignment I grant Dental Designers full power and authority to exercise my rights, under said insurance policy, to collect and receive payments thereon, to bring a legal action to exercise said rights and to do all things that I might do. I further promise to cooperate with Dental Designers in any action that I might become involved in to enforce my rights to payment under any policy of insurance.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I am financially responsible to Dental Designers for all charges incurred for which payment is not received by Dental Designers from the insurance company. I understand that many insurance companies require the patient to call the insurance company for pre-certification prior to treatment being rendered. Failure of the patient to obtain pre-certification may result in denial of payment by the insurance company.

If I have not obtained the required pre-certification and a denial of payment results, I understand and agree that i am financially responsible for these charges. I further understand and agree that I am responsible for all charges that considered not covered by my insurance policy and for care that is, in the opinion of my insurance company or their authorized utilization review agent, subsequently found to be necessary. I agree to pay any amount I receive from my insurance company to Dental Designers within thirty (30) days of treatment being rendered.

I agree that Dental Designers may, upon my default, take any action, including filing a law suit to collect all sums due. I agree to pay Dental Designers all costs of collection, including attorneys fees, court costs and collection agency's fees which may greatly increase the outstanding amount due.

I hereby authorize release of information, including record copies, as may be required by my insurance company or group policy holder, or their authorized agent for payment of my insurance claim.

I am aware that any account **over thirty (30) days past due** will incur an 18% account handling charge and billing charge on the balance due. Any ***insurance*** balance **over thirty (30) days past due** is the responsibility of the patient/account holder.

I am aware that if an appointment is **not kept or not canceled with a forty-eight (48) hour advance notice** there will be a charge of ***$40 per hour*** for each appointment. I am also aware that id a ***Saturday appointment*** **is not kept or not cancelled with a forty-eight (48) hour advance notice** there will be a charge of ***$60 per hour*** for each appointment.

_____ _____

Patient's name Date

_____

Insured Person/Guardian (if other than patient)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name_____

Address_____

City _____ State _____ Zip code _____

Telephone:_____ Email_____

Patient #_____Soc Sec #_____

Section B: to the patient- please read the following statements carefully

Purpose of consent: By signing this, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice Of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:

Dental Designers (Jessica Banks) 7474 East State Street Suite 110
Telephone :(815) 398-3800 Fax: (815) 398-3890

Right to Revoke: you will have the right to revoke this Consent at any time by giving us written notice of your revocations submitted to the contact person listed above. Please understand that revocation will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature_____ Date_____

If this consent is signed by a personal representative on behalf of the patient complete the following:

Personal Representatives Name:_____

Relationship to Patient:_____