FAMILY DENTAL OF PALATINE

New Patient Registration Form

Who can we thank for referring you to our practice? _____

Patient Information

First & Last Name: _____ Middle Initial: _____ Preferred Name: _____

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

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

E-Mail Address: _____ Preferred Method of Contact: ☐ Cell ☐ Home ☐ Work

Marital: ☐ Minor ☐ Single ☐ Married/Partner ☐ Separated/Divorced ☐ Widowed

Gender: ☐ Male ☐ Female ☐ X

Birth Date: ____/____/____ Social Security Number: _____ Driver's License/State ID: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ Phone: (____) _____

Responsible Party Information

(If someone other than patient is responsible for account and/or patient is under the age of 18)

First & Last Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

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

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

Date of Birth: ____/____/____ Social Security #: _____ Driver's License/State ID#: _____

Insurance Information

Policy Holder Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Social Security #: _____ Policy Holder Date of Birth: ____/____/____

Insurance Name: _____ Phone: (____) _____

Member ID: _____ Group # _____

Employer Name: _____ Employer Phone: (____) _____

Additional Comments:

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Medical History

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around tour 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, please explain: _____
Have you 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 taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking Oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other: _____

Do you have any of the following?

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

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

_____

_____

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.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

FAMILY DENTAL OF PALATINE

Office Policies

Broken/Cancelled Appointments: We are very appreciative of patients who arrive on time for their scheduled appointments. In the event you need to cancel an appointment, we request notice at least 48 hours in advance. As a courtesy, our office may contact you via email or phone to remind you of your appointment(s). While certain emergencies and other issues may be taken into considerations, Family Dental of Palatine reserves the right to apply a fee of $50 per half-hour of the scheduled appointment for failure to provide adequate notice. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

Guarantee of Payment/Assignment of Insurance Benefits: Unless otherwise stated, I understand that fees are due for any services rendered on the date of service. I authorize payment for services rendered to me to be made directly to this office for benefits otherwise payable to me. These payments shall not exceed the regular charges for this period of treatment**. I also understand that I am responsible to pay any charges not covered through my insurance benefits, including but not limited to non-covered services, applicable deductible and/or co-insurance as defined by my policy(es), or any fees for services in the even that I do not have insurance coverage.**

Completion of Treatment: In the event that I elect to receive treatments such as crowns, dentures, root canals, bridges, implants and other treatment that requires me to return for future visits to finalize, I understand that I am responsible to return to the office to complete treatment. These types of treatments typically require Family Dental of Palatine to Incur lab, equipment and labor costs up front. **In the event that I do not return to complete the treatment, I understand that I am still responsible to pay the full cost of treatment.**

Past-Due Balances & Collection Services: Family Dental of Palatine makes an effort to provide all patients with education and information regarding proposed and completed treatment as well as the costs associated, in order for each patient to make an informed decision regarding their treatment. Family Dental of Palatine also participates in lending programs to extend interest-free credit to qualified applications for certain procedures. However, **in the event that I do not pay outstanding balance(s), I understand that 12% interest rate will be applied to any past due balances on my account(s).** I also understand that should my past due balance be referred to an attorney or collection agency, I will be financially responsible for any additional costs incurred such as attorney fees, collection agency fees, court costs, etc.

Patient Dismissal: Our Practice takes pride in our dentistry and in the relationship with our patients who believe in quality care. Cooperation is a key element to successful treatment. Family Dental of Palatine Reserves the right to dismiss patients in the interest of customer service and quality care for all patients. Family Dental of Palatine will be happy to transfer patient records to another provider at the request and approval for any patients who are dismissed.

HIPAA Privacy Policy: The privacy of your health information is important to us. We understand that the information you have provided is personal and we are committed to protecting it. Please feel free to speak with one of our staff to obtain a copy of our Notice of Privacy Practices, if one has not been provided to you.

Patient Acknowledgment and Agreement. I agree and abide by the polices listed above. I understand that if I have any questions about these policies, I may request assistance and further explanation at any time from an Family Dental of Palatine staff member.

☐ I have received a copy of Family Dental of Palatine's Notice of Privacy Practices.

☐ I did not receive a copy of Family Dental of Palatine's Notice of Privacy Practices, but I understand that I may request a copy of Family Dental of Palatine's Notice of Privacy Practices at any time.

_____ _____

Patient/Responsible Party Signature **Date**

FAMILY DENTAL OF PALATINE

Consent for Text/E-Mail Communication

Summary of risks and benefits of using email/text:
Email/Text is a useful method of correspondence for patients. Transmitting information by e-mail/text can create a number of risks, both general and specific that patients need to be aware of if they choose this method of correspondence.

Risk of using email or text messaging
Patients are offered the opportunity to communicate with the practice and/or clinicians by e-mail. Transmitting patient information by e-mail, however, has several risks that patients should consider before giving consent. These risks include, but are not limited to:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.
- E-mail/text senders can misaddress e-mail/text.
- E-mail can be more easily falsified than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails/text transmitted through their systems.
- E-mail/text can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems
- E-mail/text can be used as evidence in court.

Conditions for the use of email or text messaging
Your provider will use reasonable means to protect the security and confidentiality of e-mail information sent. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of e-mail/text communication and will not be liable for improper disclosure of confidential information that is not caused by the clinician's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

- All e-mails from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
- You should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, issues of abuse, developmental disability, or substance abuse.
- You are responsible for informing your provider of any types of information you do not want to be sent by e-mail, in addition to those set out above.
- You are responsible for protecting his/her password or other means of access to e-mail/text. Your clinician is not liable for breaches of confidentiality caused by the patient or any third party.
- The clinician will not engage in e-mail communication that is unlawful.
- Text messaging will not include PHI and will only include an appointment reminder.
- It is your responsibility to follow up and/or schedule an appointment if warranted.

Your consent to email/text correspondence includes your understanding of the following conditions:

- Employers do not observe an employee's right to privacy in their email system, you should not use your employer's email system to receive confidential emails.
- The clinician is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct. Patient information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2 Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not enough for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse.

Informed Consent

- If you consent to the use of email, you are responsible for informing your provider of any type of information that you do not want to be sent to you by email.
- You are responsible for protecting your password and access to your email/text to ensure your confidentiality. The clinician cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.
- If you wish to discontinue emailing/texting information, you must submit written consent by mail, or an email informing Family Dental of Palatine that you are withdrawing consent to email or text information.

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail/text between clinician and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the clinician may impose to communicate with patients by e-mail/text. Any questions I may have had were answered.

☐ **Yes, I have read the above and consent to confidential e-mail/text correspondence.**
☐ **No, I do not wish to be contacted through text or e-mail.**

If you would like to consent for others in your family, please list patient(s) below:

_____ _____
Patient Name Patient Name

_____ _____
Patient Name Patient Name

_____ _____
Patient/Parent/Guardian Signature Date

_____
Patient/Parent/Guardian Printed Name

For communication purposes, please use the e-mail and/or cell phone below:

_____ (____) _____
E-Mail Address Cell Phone

Written consent can be mailed to:
Family Dental of Palatine
381 W Northwest Hwy
Palatine, IL 60067

E-Mail:
smile@familydentalofpalatine.com