REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR: ____________________

Residence Address	CITY:
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN - -	DOB / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	
Occupation	Will you receive calls at work? ☐ Yes ☐ No
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Name & Telephone	

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company		
Address		
Telephone		
Subscriber's Name/ Relationship to Patient	/	/
Name of Group Policyholder or Union		
Group Policy # / Individual Policy #	/	/
Effective Date / Time Limit for Claims	/	/
Pre Estimate Required	☐ Yes ☐ No	☐ Yes ☐ No
Method of Payment	☐ UCR ☐ Schedule of Payments ☐ Other	☐ UCR ☐ Schedule of Payments ☐ Other
Coinsurance	Company ____ % Patient ____ %	Company ____ % Patient ____ %
Deductible	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ ____ ☐ Lifetime $ ____	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ ____ ☐ Lifetime $ ____
Plan Covers Orthodontics	☐ Yes ☐ No	☐ Yes ☐ No
Other		

If credit card payment is accepted: Name of Card ____________________

Card # ____________________ Expiration Date ____________

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REGISTRATION FORM / MEDICAL-DENTAL HISTORY page 2

Medical History

INSTRUCTIONS

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission."

Patient's Initials__________ Dentist's Initials ___________

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

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1. Name, address & phone # of your physician ____________________
2. Date of last visit to your doctor _________ Purpose of visit ____________________
3. Do you suffer from any disability?_______ If yes, describe ____________________
4. Have you ever, or do you now take illegal drugs?_______ If yes, what drugs, and when taken? ____________________

   Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV-positive? ________ If yes, describe and provide current status. ____________________
6. Do you now have, or have you ever had a venereal disease? ______ If yes, describe.____________________
7. Have you ever had, or do you now have hepatitis? ______ If yes, describe. ____________________
8. For females: Are you pregnant?________ If yes, when are you due? ____________________
9. For females: Are you taking birth control pills? _________ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*
10. Are you taking any drugs or medications?_______ If yes, list and describe amounts and purpose. ____________________

    Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.
11. Have you ever had an allergic reaction to medication?_______ If yes, describe.____________________
12. Have you lost weight recently? _________ If yes, describe. ____________________

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? ____________________
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? ____________________
15. Stomach or intestinal disease? ____________________

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Medical History [continued]

16. Abnormal blood pressure, excessive bleeding, or anemia? ____________________
17. Breathing problems, asthma, tuberculosis, or hay fever? ____________________
18. Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment? ____________________
19. Diabetes? ____________________
20. Kidney problems or renal dialysis? ____________________
21. A stroke, convulsions, or fainting spells? ____________________
22. Tumors or growths? ____________________
23. Arthritis or rheumatism? ____________________
24. Have you ever had a major operation? __________ Is yes, describe. ____________________
25. Have you ever had a serious injury to your head or neck? __________ If yes, describe. ____________________
26. Are you on a special diet? __________ If yes, for what reason and describe. ____________________
27. Do you smoke? __________ If yes, describe type and quantity. ____________________
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? __________ If yes, when and describe. ____________________
29. Do you consume any alcoholic beverages? If yes, how much and how often? ____________________
30. Are there any other problems about your health of which you are aware? ____________________
31. For children under 10 years old: Was the child born by Cesarean Section? ____________________
32. Females: Are you currently taking any bisphosphonate medication? ____________________
33. Have you had any prosthetic joint replacement? ____________________

Dental History

1. Name of previous dentist ____________________ Date of your last visit __________
2. Reason for your last visit (or series of visits) ____________________
3. Do you have any of your X-rays or dental records? ____________________
4. Chief dental complaint if any?

In respect to any previous dental treatment have you:

5. Ever fainted? ____________________
6. Had an allergic reaction? ____________________
7. Had abnormal bleeding? ____________________
8. Any other complications during or following dental treatment? __________ If yes, describe. ____________________

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Dental History [continued]

9. Do your gums bleed on brushing or eating? ______
10. Does food catch between your teeth? ______
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? ______
12. Are any of your teeth sensitive to heat, cold, or pressure? ______
13. Do you grind your teeth or clench your jaws? ______
14. Do you have pain or clicking in the jaw joint in front of your ear? ______
15. Have your jaw muscles ever been sore? ______ If yes, describe. ______
16. Are there any sores or growths in your mouth? ______
17. Do any of your teeth ache? ______
18. Do you have any other dental complaint? ______

To the best of my knowledge, the foregoing questions have been accurately answered.

NOTE: A change in your health status should be reported to the office immediately.

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

Patient's Initials______ Dentist's Initials______

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: ______ Signature ______

Witness ______ Print Name ______

If other than patient, indicate relationship ______ Date / /

Dentist's History Review & Significant Findings ______

Signature Dr. ______ Date / /

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{Michael E. Sullivan, DDS, PC}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice

of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ______Individual refused to sign
- ______Communications barriers prohibited obtaining the acknowledgement
- ______An emergency situation prevented us from obtaining acknowledgement
- ______Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

{Michael E. Sullivan, DDS, PC}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________________ E-mail: ______________________________

Patient Number: ______________________________ Social Security Number: ______________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, 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 the 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 and completely 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: Ellen Gervase

Telephone: (630) 530-0770 Fax: (630) 530-9287

E-mail:

Address: 386 N. York Road, Suite 203, Elmhurst, IL 60126

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent 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.

SIGNATURE

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, payment activities and heath care operations.

Signature: ______________________________ Date: ______________

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

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

FINANCIAL POLICY

Thank you for choosing us to provide your dental care. We consider it an honor that you have chosen us to do so. It is of utmost importance to provide our patients with open communication, especially with the area of finance. If you have any questions or concerns about this Financial Policy, please do not hesitate to ask our office staff.

PAYMENTS

We accept cash, personal checks, Visa, MasterCard, American Express, Discover, and Care Credit.

FINANCE CHARGE

Interest of 1.5% will be applied to all balances after 60 days of the service date at the end of each month.

OVERDUE ACCOUNTS

Effective February 1, 2010, any account that is 60 days overdue will immediately be turned over to a third party collection agency. In the event that this occurs, you agree to pay collection costs and reasonable court costs/attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

DENTAL INSURANCE

As a courtesy, we will gladly submit a pre-treatment estimate and file your claims for you. However, your insurance policy is a contract between you and your insurance company. Although we may inquire an estimate from your insurance company it is just that, an estimate. All charges that are not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Payment is due in full when services are rendered and your insurance company reimburses you for the portion they cover.

CANCELLATION POLICY

Our practice is dedicated to assuring that all of our patients have access to their doctor when necessary, and due to our growing patient base, this can be challenging. When patients cancel without an adequate notice, it can make it difficult for our staff to appoint another person, whom is in need of the doctor's care, to that time slot. We strive to spend an inordinate amount of time with our patients because we are committed to providing individualized attention and want to respect their time. If a previously scheduled appointment does not work are you planned, we appreciate and anticipate that you will contact us as soon as possible. Failure to give a 24-hour notice will result in a $75 charge being placed on the account.

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I have read and understood this document in its entirety, outlining our policies of Dr. Michael E. Sullivan, DDS, PC. Without any reservations, I agree to abide by the policies outlined.

Patient's Name: ______________________________

Patient's Signature: ______________________________

Date: ______________________________